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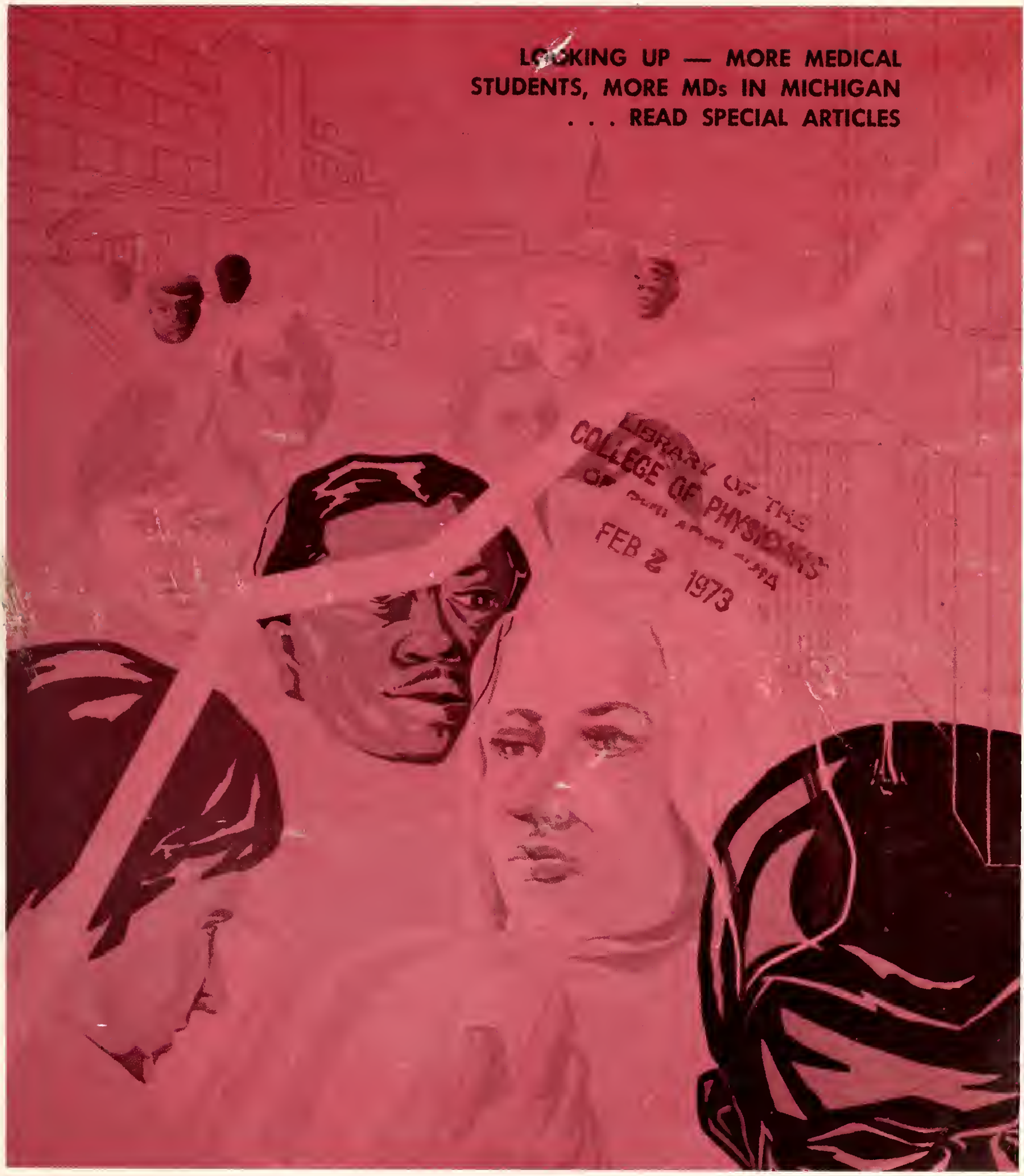
DICAL MANPOWER
SPECIAL ARTICLES

MDS

Michigan Medicine

OFFICIAL JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY • VOLUME 72, NUMBER 1
JANUARY 1973



LOOKING UP — MORE MEDICAL STUDENTS, MORE MDs IN MICHIGAN . . . READ SPECIAL ARTICLES

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1972 Fall MSMS House of Delegates Digest of Proceedings, see page 73 inside

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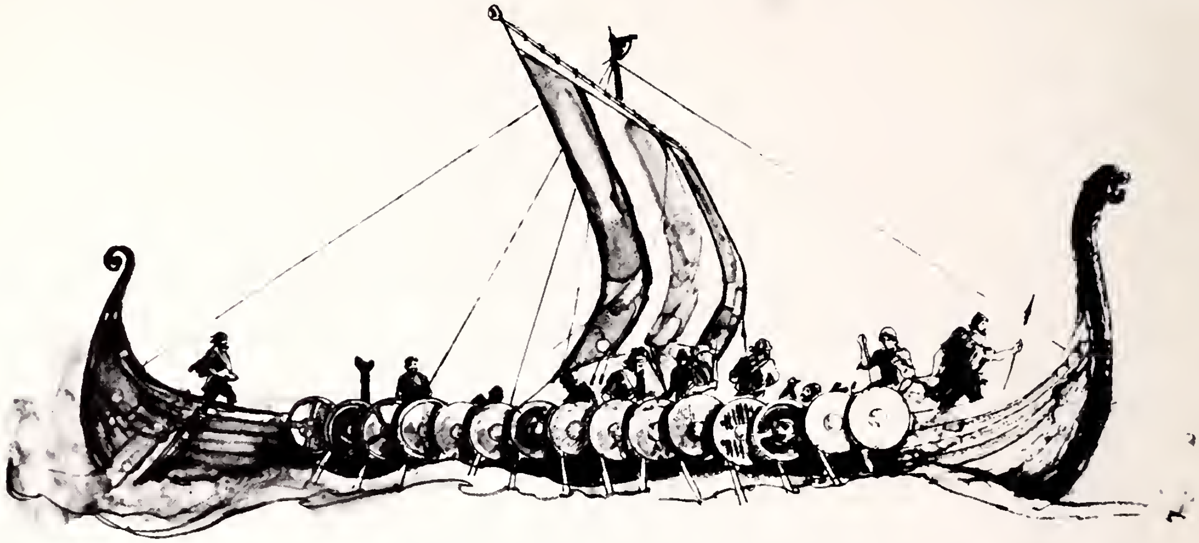

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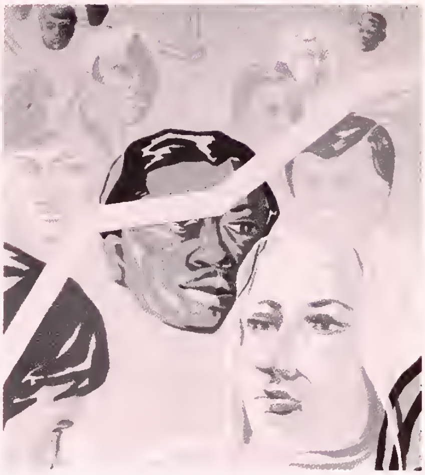
QUESTION: How effective has MSMS been in helping to expand the Michigan medical schools? What is the situation in the nation?

QUESTION: How is Michigan doing for enough doctors? How many are being licensed now? How many are coming from foreign countries? What's the national picture?

THE ANSWERS TO THESE and other related questions appear on these special four pages of *Michigan Medicine.* The subject was researched and the articles written by Herbert A. Auer, Manager of the MSMS Department of Communications. Mr Auer also serves as staff assistant to the MSMS Education Liaison Committee, the MSMS Liaison Committee with Medical Students, the MSMS Committee on Public Relations—all active along with other MSMS committees in the broad area of physician manpower in Michigan.

This four-page layout begins a new 1973 series of features about medical issues of concern to physicians and the Michigan State Medical Society. Your comments will be welcomed.

—Judy Marr, Managing Editor



Situation Improving—More Medical Students, More Doctors in Michigan

How is Michigan or the nation doing in the MD manpower situation?

Decide the answer after reading these facts:

FACT 1: Michigan and the nation have more students enrolled in the first year of medical school now than ever before.

FACT 2: Michigan and the nation have more medical students in the 108 medical colleges than ever before.

Related Articles:

These four pages provide several articles that tie into this subject of physician manpower. Be sure to also read . . .

Page 2—Chart of Michigan Medical School Enrollments.

Page 3—List of Related Questions to Consider.

Page 4—Chart of Michigan Physician Population.

Page 4—Report of MSMS Efforts.

FACT 3: Michigan and the nation had more graduates from medical schools last June than ever before.

FACT 4: Michigan and the nation issued a record number of licenses in 1971.

FACT 5: Michigan and the nation have more licensed physicians than ever before.

* * *

The critics of medicine don't realize the following factors either:

FACT 6: Michigan and the nation have more black students and more women enrolled in medical schools than ever.

FACT 7: Michigan is spending more to finance medical education than ever before.

FACT 8: Michigan has more foreign-trained physicians today then ever before in training or in practice, and so does the nation.

FACT 9: The three Michigan medical schools are utilizing community hospitals and practicing physicians as preceptors more than ever before.

Michigan Enrollments Set Record

The three Michigan medical schools now have total enrollments of 1,951 students for an all-time high. This figure is boosted not only by the growing student body at the six-year-old Michigan State University College of Human Medicine but also by the record enrollments at the University of Michigan and Wayne State University.

MSU made news last June when it graduated its first 30 doctors. Wayne State University hit the headlines this past fall when it enrolled 241 first-year medical students for the third largest class in the entire nation. The University of Michigan attracted special attention last fall when 50 1972 high-school-graduates began a

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special six-year course towards a medical degree.

All three Michigan schools have projected further increases in enrollments.

Chart 1 shows the increases at the three Michigan medical schools.

National Enrollments at Peak

First-year enrollments in the nation jumped from 11,348 in the fall of 1970 to 12,361 in the fall of 1971, and the total medical school aggregate rose from 40,487 in the 1970-71 school year to 43,650 the following year. The 43,650 figure doubles the total enrollment of just a decade ago. And, current enrollments will set another record.

The AMA Division of Medical Education reports that five new schools were opened in 1971 to bring the total to 108, and those five added 170 to the first-year totals. Total enrollment this past fall has been estimated at 13,300 freshmen for another record. Three new schools began last fall and one more this month for a new total of 114 medical schools.

The AMA reports that there were 29,172 applicants for the fall of 1971, 4,185 more than the year before and the largest total ever. These 29,172 men and women submitted a total of 210,943 applications for the 12,361 available places.

The 10 states with the most entering medical students were New York, California, Pennsylvania, Illinois, Michigan, Ohio, New Jersey, Texas, Indiana and Florida in that order. Ninety-one percent of the freshmen had completed four years or more of college, the same percentage as the year before. Eighty-two percent had bachelor's degrees, 5% had master's and 2% had doctorates.

Of the first-year students 44.6% entered U.S. private medical schools and 55.4% entered public medical schools. Of the men applicants, 41.9% were accepted, and of the women applicants 45.1% were accepted.

MICHIGAN MEDICAL SCHOOL ENROLLMENTS

U-M	1967-1968	1971-1972	1972-1973
First Year	205	225	287*
Total Students	800	882	956
Graduates	186	188	207
WSU			
First Year	139	208	240
Total Students	537	634	742
Graduates	125	127	121
MSU			
First Year	26	85	88
Total Students	52	195	253
Graduates	0	30	32

---

*U-M enrolled 50 additional 1972 high school graduates in a new six-year, MD-degree program in the fall of 1972.

The AMA reports that the percentage of black students in US medical schools has more than doubled since 1968-69. The number of blacks totaled 2,090 or 4.8% of the total in 1971-72. Whereas 63% of all black students attended Howard or Meharry in 1968-69, their predominantly black enrollments in 1971-72 accounted for only 27% of the enrollments in 1971-72.

In commenting on the increases in medical students and schools, the AMA Division of Medical Education rates PL 92-157 (The Comprehensive Health Manpower Training Act) as "the most important federal legislation ever enacted for the support of medical education." The Act, signed by President Nixon in 1971, will continue through 1974.

New Licenses Set Record in Nation

The total number of medical licenses issued in the USA in 1971 was a record 29,406 or 2,338 more than the year before. The AMA Council on Medical Education reports that 10,765 of the new licenses were awarded following examination and 18,641 by reciprocity or endorsement.

The figures in Michigan for 1971 were 228 new licenses after examination and 362 by reciprocity or endorsement for a total of 641.

The 641 places Michigan 15th in the nation, far behind California with 3,376, New York with 2,799 and Florida with 2,093.

In 1971, 600 candidates were examined in Michigan and 452 passed. There was a 58.1% failure rate among the 217 foreign-trained who were examined in Michigan. Of all 600, 452 passed and 140 failed for 22.3% failure rate. The national failure rate averaged 27.2% with the highest in New Hampshire with 80%.

Of the 29,406 licenses issued in 1971, a total of 12,257 were to doctors receiving their initial license. That was an increase of 1,225 initial licenses over 1970—the largest gain ever in one year in the USA.

More Doctors in Nation Than Ever

There are 302,708 licensed doctors of medicine in the nation, as of Dec. 31, 1971, the latest total available. That figure is 7,775 over the previous year.

While the number of physicians has increased every year, discussions continue about a doctor shortage, problems of maldistribution, rising levels of expectations by patients, etc. Experts at the Department of Health, Education and Welfare estimate the shortage at 50,000 and point out the most severe shortages are in the inner-city ghetto, rural areas, and state mental hospitals.

Some who question the shortages contend the "minimum norm" of 1.85 doctors for every 1,000 people is no longer an accurate measurement because of changing patterns of delivery of health care, better transportation, etc.

The physician population has grown 28% since 1960 while the overall population is up 14%.

Foreign Physician Influx Continues

The increase in total physicians reflects the continuing movement of foreign-trained doctors to the USA. The annual report of the US Immigration and Naturalization Service shows that for the year ending June 30, 1971 there were 10,947 foreign physicians who entered the USA—up 2,424 over the previous year. The number migrating as permanent residents was 5,756 (almost double the 1970 figure).

The 10,374 foreign graduates who were examined in the USA in 1971 came from almost 400 different medical schools in 50 countries. The highest number of 1,311 candidates was from the University of Santo Tomas.

One-fourth of the initial licenses in the USA are issued to foreign-trained.

Michigan and some other states in the past have required that applicants for MD licenses had to be a citizen or have proof of valid second naturalization papers. State Attorney General Frank J. Kelley recently ruled that requirement was unconstitutional. He found such a requirement to be a denial of equal protection under law. In part he pointed out that if an alien meets all the requirements pertaining to education and practice, there would be no rational basis for distinguishing between citizens and aliens.

No Accurate Figures on Michigan Supply

Proponents of various special interests have a field day in Michigan grabbing figures

(Continued, Page 4)

Many Tough Questions Need Answers in Michigan

By Robert M. Leitch, MD, Chairman, MSMS Council

Let me assure all who are pointing a finger at doctors that MSMS leaders and committees *are seeking answers* to many of the complex questions about physician manpower in Michigan.

MSMS leaders have conferred often with members of the State Board of Registration in Medicine, the three deans, members of the Michigan legislature, leaders of the Michigan Health Council, SAMA officers, reporters, etc., about the related parts to the puzzle. And I know that many component medical societies, and state medical specialty societies, as well as the Wolverine and Detroit Medical Associations, also are moving forward. Activities are whittling away at the problem. Studies are underway to facilitate further solutions.

The following set of questions has just been sent by me to our key committees and to others asking them to provide the answers as quickly as possible. May I ask that you think on these too and please send me any ideas you personally have? Thank you . . .

1. Is there a shortage of doctors? What kind? Family Physicians? Pediatricians? Internists? Ophthalmologists? Etc.?
2. Where is there a shortage of physicians because of poor distribution? Inner City of Detroit? Small, rural Michigan communities? Upper Peninsula? Fast-growing suburbs?
3. What can be done in the communities with interns and residents to make these young doctors and their families feel more welcome, etc.?
4. What could be done to fill more of the hospital positions in Michigan for interns and residents?
5. What roles can MSMS and the Michigan Health Council play to improve further the operation of the Physician Placement Service?
6. Is there a relationship (and how much) between the decisions made by new doctors to locate in certain communities and regional differences in reimbursements by government and Blue Shield?
7. In what ways can MSMS assist foreign-trained physicians in Michigan to communicate better with fellow physicians and paramedical people? With the patients? With the communities?
8. Can local communities develop new ways to assist medical students who need additional financial support and assistance?
9. Will the new family practice preceptorship programs being launched jointly by the three medical schools help encourage students to later practice in Michigan communities?
10. Will the increased use by the medical schools of community hospitals for more of the clinical training later increase the number of physicians in those communities?
11. Would the establishment of Departments of Family Practice, with family physicians as department heads, at the three medical schools result in decisions by more medical students to enter family practice?

MSMS Improves Medical Manpower Picture

Probably at no time in the 107-year history of MSMS have the physicians of Michigan been working so conscientiously to expand the medical schools and to seek more doctors for Michigan.

The following brief reports describe some of the many MSMS efforts.

MSMS has a new dedication to work more in the field of physician placement. MSMS is now seeking ways that the Society can cooperate with component societies to recruit physicians, and with interested physicians who are seeking to locate in Michigan. The Michigan Health Council has conducted such a Placement Service for some time. MSMS is exploring the best ways to complement and supplement the MHC work.

MSMS continues to urge the legislature to increase its funding to the three medical schools so the freshmen classes, for example, can be increased further.

One of the MSMS committees is studying the need for a possible fourth medical school in Michigan, or the possibilities of one or more two-year medical schools. The MSMS House in 1972 supported the current MSU feasibility study of ways to train medical students in the Upper Peninsula.

In response to requests from physicians and communities, MSMS took the leadership to successfully have the state legislature repeal the law which required foreign-trained physicians to pass the basic science examination.

MSMS first took action in 1965 asking for a feasibility study of possible uses in Michigan of physician assistants. MSMS later endorsed the four-year, baccalaureate-degree program at Western Michigan University to train primary care physician assistants. MSMS obtained legislation in 1972 that will permit the physician to delegate to such a physician assistant and thus provide legal protection for both the physician and the PA. (There are new assistant programs also at Mercy College and Marygrove College, both in Detroit.)

The MSMS House of Delegates requested a study of why many graduates of Michigan medical schools leave Michigan for their internships and residencies. The MSMS Education Liaison Committee and the MSMS Liaison Committee with Medical Students are cooperating now with the three medical schools in an extensive research survey of recent graduates. The Committee will make recommendations to the House of Delegates at the Spring Session hoping to turn this situation around.

To expose medical students to the practice of medicine in Michigan communities, MSMS annually coordinates the SAMA-MECO project of the three Michigan SAMA chapters. In 1970, 11 students were placed in a pilot project which grew in 1972 when MSMS placed 92 students in 56 hospitals in 51 different Michigan communities.

MSMS House is on record as encouraging the three medical schools to establish departments of family practice as one of the elements to produce more family physicians.

Many other MSMS activities re medical manpower could be reported . . .

Continued: Situation Improving

of possible shortages of doctors in the state. There is general agreement among physicians, public officials, etc., that there are distribution problems.

There have been no scientific surveys of Michigan medical manpower needs for some time. Figures showing the number of doctors licensed in Michigan are in Chart 2.

The Michigan Health Council, established by MSMS in 1943, operates a MD Placement Service and can provide information about the communities reportedly looking for physicians. MHC also has attempted to estimate shortages from time to time in the various regions of the state.

There seems to be agreement that more family physicians are needed in Michigan . . . that more doctors are needed in the inner city of Detroit . . . that many rural communities are looking for a doctor . . . that the Upper Peninsula has fewer doctors per 1,000 than the balance of the state.

MSMS is exploring possible sources of necessary funding for a statewide survey of physician distribution and need.

MICHIGAN DOCTORS OF MEDICINE

(Following figures are from State Board of Registration in Medicine, 1971-72 report)

13,281	MD's licensed by Michigan
9,090	licensed MD's in Michigan
3,509	licensed by Michigan, but out of state
579	licensed by Michigan, but in military
103	licensed, but in Peace Corps, Missionary Work, etc.

* * *

915	Temporary Annual Licenses for Private Practice (awaiting U.S. Citizenship) issued to graduates of Canadian and Foreign medical schools
8	Temporary Annual Licenses for Private Practice issued to non-citizens who were graduates of American medical schools

* * *

1,518	Temporary Annual Licenses for Residency Training only issued to graduates of U.S., Canadian and Foreign medical schools
205	Permits for Internship issued to graduates of foreign medical schools

President's page

'MSMS wants you'

John J. Coury, MD
MSMS President

The famous "Uncle Sam Wants You" poster can be paraphrased in our case to: "Your Medical Society Wants You."

And what is needed most is your active participation in your component medical society, MSMS and the AMA.

This is the time of the year, when the medical organizations at all three levels ask members to renew your membership for the new calendar year. Of course, the financial support is necessary to mount action programs, but equally important is your pledge to personally participate in the direction and impact of the medical societies.

The participation, I feel, is essential because physicians today face one major issue among all the other challenges—the future course of health care must remain in the hands of the physicians!

I do not believe that it is arrogant to say that men and women who are highly trained and dedicated to serve the health care needs of the American people are the most qualified to decide its future.

But in order to speak and be heard, we must have unity.

It is necessary that our membership be continuous.

In some component societies, membership has never been higher, and the membership of MSMS every year hits a new record.

The rate of growth of the MSMS can be improved and a multi-front campaign has been started. Membership benefits have been expanded, communications have been increased, opinions are being asked.

The AMA reports that the membership decline has stopped and leveled off at 155,000. There are ambitious AMA plans and activities to appeal to former members to rejoin, to encourage the 50,000 house-staff members to join and become active.

In Michigan, some physicians who are members of the component society and MSMS choose not to continue as AMA members. This, I am convinced, is an error. As a member of the AMA House of Delegates I can assure you that the AMA is responding with vigor and new enthusiasm to current issues. It is vitally important that we all support the AMA. It is the only national spokesman we have. Without the AMA there would be no organization that would, or could, speak for us on critical scientific and socioeconomic issues. Membership at all three levels provides the opportunities for maximum, unified action in legislation, continuing medical education, communications, public service, and the other fields.

There are unlimited openings for every concerned, interested physician to be an active participant in the component society meetings and to volunteer for service on committees. MSMS certainly wants each member to respond to questionnaires about issues, to submit ideas for improvements and to volunteer for committee work.

Please do not hestitate to speak. Tell your component society, MSMS and the AMA how all can serve you better in 1973. I am honored to be your president, but in order to do my job I need your help, not only as a dues-paying member, but as an active participating physician.

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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The cover of the January journal is the first by Lansing artist Marvin Pearson, who will be preparing all 1973 covers to tie in with our new series of four-page presentations on issues of major concern to Michigan doctors. The first in this year-long series is on pages 1-4 of this issue.

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Publication of Michigan Medicine is under the direction of the Publication Committee, Michigan State Medical Society. The scientific editor is responsible for the scientific content. The managing editor is responsible for the production, correspondence and contents of the journal. He and the executive editor share final responsibility of the entire publication.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

MSMS no smoking campaign widely noted

Approximately 10,000 "Thank you for not smoking" cards have been distributed by MSMS to individuals, interested hospitals, business firms, churches, schools, lawyers, and related health organizations. This includes the cards which were first inserted in the July issue of Michigan Medicine.

Requests for 50,000 AMA leaflets discouraging smoking and an additional 5,000 of the Teacher's Guide to Smoking and Health have been received by MSMS and plans are to mail them out this month if funds are available.

These are the results of the stepped-up anti-smoking campaign underway by MSMS and aimed particularly at physicians and youth.

The Michigan Health Council predicts that during the current fiscal year Michigan will gross $140,000,000 in cigaret taxes, with sales up two per cent over a year ago. Sales have increased by $60,000,000 in the past five years. An all-time record was set in September, when a gross tax of $12,176,365.89 was reaped on the sale of 110,694,235 packages of cigarets.

If I were editor . . .

If you had the opportunity to be editor of **Michigan Medicine** for one year, what would you do?

What new features would you develop? Would you change the entire scope of the magazine? Would you change its emphasis? Would you alter its format, make it a different size, create a new look? What new features would you develop, what current offerings would you drop?

How effective do you think the journal is now, and why or why not? Do you enjoy reading it?

These are questions the current editors would very much like to have answered by the readers of **Michigan Medicine.** If you have ideas and suggestions, jot them on a postcard and mail to:

Judith Marr, Managing Editor
Michigan State Medical Society
120 W. Saginaw St.
East Lansing, Mich. 48823

For the best and most constructive letter in the opinion of the journal staff, we will pay an editorial consultant's fee of $25. All letters must be postmarked no later than April 30, 1973. Many may be published. All readers of **Michigan Medicine** are eligible to participate.

Sally's back in sew biz! After an arthritic flare-up.

nportant Note: This drug is not a simple analgesic. Do
ot administer casually. Carefully evaluate patients be-
re starting treatment and keep them under close su-
ervision. Obtain a detailed history, and complete
iysical and laboratory examination (complete hemo-
am, urinalysis, etc.) before prescribing and at fre-
ient intervals thereafter. Carefully select patients,
oiding those responsive to routine measures, contra-
dicated patients or those who cannot be observed fre-
iently. Warn patients not to exceed recommended
sage. Short-term relief of severe symptoms with the
nallest possible dosage is the goal of therapy. Dosage
iould be taken with meals or a full glass of milk. Sub-
itute alka capsules for tablets if dyspeptic symptoms
cur. Patients should discontinue the drug and report
imediately any sign of: fever, sore throat, oral lesions
ymptoms of blood dyscrasia), dyspepsia, epigastric
ain, symptoms of anemia, black or tarry stools or other
vidence of intestinal ulceration or hemorrhage, skin re-
ctions, significant weight gain or edema. A one-week
ial period is adequate. Discontinue in the absence of a
vorable response. Restrict treatment periods to one
eek in patients over sixty.
dications: Acute gouty arthritis, rheumatoid arthritis,
ieumatoid spondylitis.
ontraindications: Children 14 years or less; senile pa-
ents; history or symptoms of G.I. inflammation or ul-
eration including severe, recurrent or persistent dys-
epsia; history or presence of drug allergy; blood
yscrasias; renal, hepatic or cardiac dysfunction, hy-
ertension; thyroid disease; systemic edema;
omatitis and salivary gland enlargement due to the
rug; polymyalgia rheumatica and temporal arteritis;
atients receiving other potent chemotherapeutic
gents, or long-term anticoagulant therapy.
larnings: Age, weight, dosage, duration of therapy, ex-
tence of concomitant diseases, and concurrent potent
iemotherapy affect incidence of toxic reactions. Care-
illy instruct and observe the individual patient, espe-
ally the aging (forty years and over) who have
creased susceptibility to the toxicity of the drug. Use
west effective dosage. Weigh initially unpredictable
enefits against potential risk of severe, even fatal, re-
ctions. The disease condition itself is unaltered by the
rug. Use with caution in first trimester of pregnancy
nd in nursing mothers. Drug may appear in cord blood
nd breast milk. Serious, even fatal, blood dyscrasias,

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including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight, complete weekly (especially for the aging) or an every two week blood check, pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug, its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia, ulcerative stomatitis, salivary gland enlargement. (B)98-146-070-G

Serious side effects do occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings, contraindications and adverse reactions.

For complete details, including dosage, please see full prescribing information.

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msms action

MSMS at work on 1973 SAMA-MECO summer project

The Michigan State Medical Society, through the Education Liaison Committee chaired by Brock E. Brush, MD, again in 1973 is assisting Michigan Student American Medical Association Chapters with their Project for Medical Education and Community Orientation.

In the program, medical students spend eight to 10 summer weeks in hospital-based programs, supervised by physicians, learning about community medical practice. The program is designed to complement students' academic programs and to encourage their interest in practicing in Michigan communities.

In the successful program conducted in 1972, 92 students took part in programs in 56 hospitals in 51 communities. Of 72 students who responded to a summary questionnaire, all said they would recommend the program to other students.

Ninety-three per cent of those responding said they plan to practice in Michigan. Fifty-eight per cent said the program had made them more interested in practicing in Michigan and an equal percentage said they would like to return to practice in the communities where they spent the summer.

Only one-half of the students who applied in 1972 could be placed and it is anticipated that a larger number will seek places in 1973. For additional information about the program, please contact the SAMA-MECO Project, c/o Department of Communication, MSMS, 120 W. Saginaw St., East Lansing, Michigan 48823.

MSMS supporting health screening

Component societies are being urged by MSMS to work jointly with county health departments in implementing the federally required early health screening of children under 21 who are eligible for Medicaid.

Michigan is one of only two remaining states who are not yet following the requirement that the program for early and periodic screening, diagnosis and treatment of children be carried out.

Clyde T. Hardwick, PhD
1915 - 1972

MSMS members and staff were shocked and saddened to learn of the death Nov. 21 of MSMS Economic Consultant Clyde T. Hardwick, PhD, Houghton. He was 57 years old.

Since 1970, Doctor Hardwick had been first dean of the School of Business and Engineering at Michigan Technological University.

Previously, Doctor Hardwick had served at the University of Detroit for 24 years, including four years as associate dean of the School of Business and Engineering Administration.

Doctor Hardwick, a native of St. Paul, Minn., was a widely-known lecturer on business management, consultant to many industries and governmental agencies and author of a number of articles and books. He became MSMS advisor in December, 1961.

He earned his doctoral degree at the University of Michigan in 1956 and did post-doctoral work under a Ford Foundation Fellowship Grant at Williams College. He specialized in administrative strategy, industrial training, organization and management, and purchasing.

Doctor Hardwick leaves his wife, Evelyn, a daughter, Mrs. Sandra Oliver, three sons, C. Patrick, Mark and Brian, and 10 grandchildren.

Doctor Hardwick served MSMS in many ways, most of which were behind the scenes as advisor to committees, the Council, the leadership and the headquarters staff.

In the 11 years he served as consultant to MSMS he published papers on health care and private practice and spoke many times before component societies and MSMS conferences.

"Yet, his most important and lasting contribution," comments MSMS Director Warren F. Tryloff," will be his economic and management advice and his important role in reshaping the management team. His insight into the organization and staff of MSMS made him a key person providing continuity, during times of change.

"His loss to the society's staff is immeasurable and he can never be replaced. A friend and knowledgeable advisor who is wise also is not often to be found and then only by chance."

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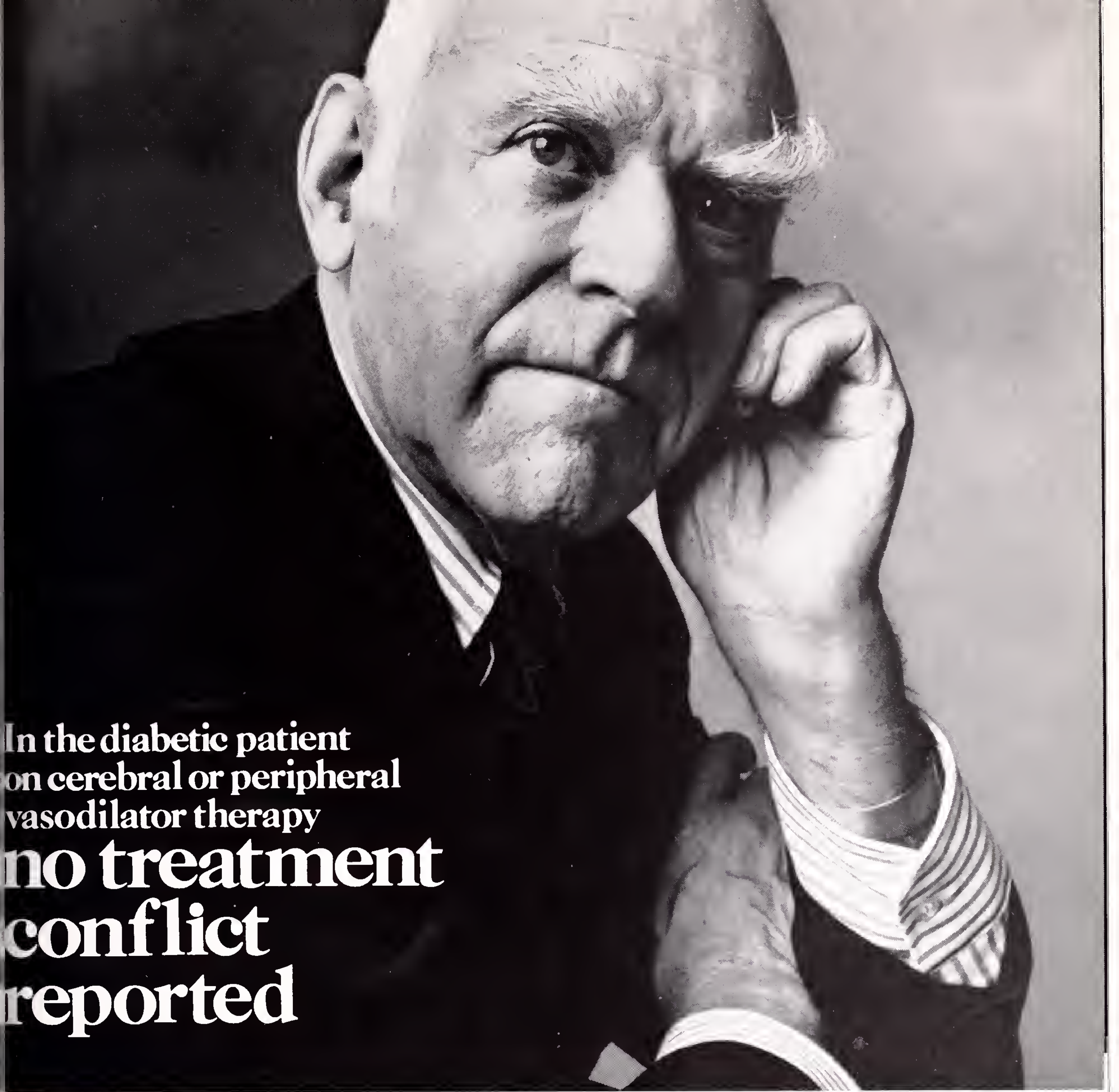

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There are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

INDICATIONS: Based on a review of this drug by the National Academy of Sciences–National Research Council and/or other information, the FDA has classified the indications as follows:
Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

COMPOSITION: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

DOSAGE AND ADMINISTRATION: 10 to 20 mg. three or four times daily.

CONTRAINDICATIONS AND CAUTIONS: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

ADVERSE REACTIONS: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

SUPPLIED:
Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose
20 mg.—bottles of 100, 500 and Unit Dose

REFERENCE: 1. Samuels, S. S., and Shaftel, H. E.: J. Indiana Med. Ass. 54:1021-1023 (July) 1961.

Mead Johnson
LABORATORIES

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Two segments of "Prescription for Health," the MSMS-sponsored radio program which is aired over 30 Michigan public radio stations, were taped recently by Thomas C. Payne, MD, Lansing, center, with Paul Werner, Holt, MSU senior medical student, who is host of the program. The studio is located on the MSU campus.

And now . . . "Prescription for health" (starring MSMS members)

By Jeanne Smith
MSMS Department of Communications

"Prescription for Health," the radio voice of the Michigan State Medical Society, is regularly reaching listeners in 30 Michigan communities.

Produced by the MSMS Department of Communication, the radio series features Michigan physicians as guests for interviews on a wide range of health topics.

Host for the program is genial Paul Werner, a fourth year student in the Michigan State University College of Human Medicine. Paul's previous experience in radio and his medical school background make him an ideal choice for host for the program.

Informality is the key of the discussions. Structured questions and answers are shunned. Paul and his guest go over the ideas they want to cover and then take to the air. Because the programs are taped, a false start isn't a disaster.

The programs are taped at MSU's Instructional Media Center in East Lansing and distributed by the University of Michigan radio station, WUOM, for broadcast and distribution to other stations. The program, part of the U of M's weekly radio service, is carried by stations in Toledo, DeKalb, Ill., and Los Angeles in addition to those in Michigan. The Armed Forces Radio-TV Service also receives the 15-minute programs.

Program topics are varied. Some programs deal with MSMS or county society activities. Lee Pool, MD, of Grand Rapids, described the GR emergency service project of the Kent County Medical Society and Donald R. McCorvie, MD, of Williamston, spoke on MSMS concerns with rural health care services.

Thomas C. Payne, MD, of Lansing, recently taped programs on physicians' activities in the legislative area and efforts by MSMS and the Michigan Hospital Association to encourage proper use of hospital emergency departments.

John H. Kitchel, MD, of Grand Haven, was the guest for a program about MSMS environmental concerns.

Other programs dealt with specific medical concerns. John Grigg, MD, of Bay City, discussed cosmetic surgery and euthanasia and Thomas Berglund, MD, of Kalamazoo, was a guest for programs on smoking and health and vasectomy.

Snowmobile safety, Michigan State University's study of feasibility of medical education in the Upper Peninsula and women in medicine are among upcoming program topics. Twenty guests made radio tapes during 1972.

Following is a list of Michigan stations which regularly carry the program. Sample tapes can be supplied to other interested stations by the MSMS Department of Communication on request.

WUOM	Ann Arbor	WEXL	Royal Oak
WAAM	Ann Arbor	WKNR	Dearborn
WHMI	Howell	WOAP	Owosso
WLDM	Detroit	WFBE	Flint
WVAC	Adrian	WGER	Bay City
WABJ	Adrian	WKYO	Caro
WHSB	Alpena	WSGR	Port Huron
WMPC	Lapeer	WSOO	Sault Ste. Marie
WZND	Zeeland	WGGL	Houghton
WDMJ	Marquette	WKZO	Kalamazoo
WJFM	Grand Rapids	WTAC	Grand Blanc
WDRQ	Detroit	WDEE	Detroit
WJIM	Lansing	WGRD	Grand Rapids
WNRZ	Ann Arbor	WLAV	Grand Rapids
		WGON	Munising

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☐ Pyopen (disodium carbenicillin) vials for injection equivalent to 1 gm. and 5 gm. of carbenicillin.
☐ Bactocill (sodium oxacillin) capsules equivalent to 250 mg. and 500 mg. oxacillin and vials for injection equivalent to 500 mg. and 1 gm. oxacillin.

Small doses

Michael J. Brennan, MD, Detroit
is the 1972 recipient of the Stritch Medal of Honor, presented by the Loyola University School of Medicine for his "high degree of professional competence, resourcefulness, benevolence and dedication to his work in the field of cancer." Doctor Brennan established the nation's first medical oncology unit at Ford Hospital 20 years ago and introduced the use of chemotherapy to the modes of cancer treatment.

George Blum, MD, Detroit,
is new president of the Detroit Pediatric Society.

Norman E. Clark, MD, Birmingham,
is the recipient of an Outstanding Friend of the Libraries Award from the Michigan Library Association. The award was made in honor of Doctor Clark's presentation of a 2,300 volume collection of rare children's literature to the Central Michigan University Library. The collection, including some books that date back to 1661, is considered one of the top four in the U.S.

Paul Connolly, MD, Detroit,
is new medical director at Harper Hospital, Detroit. He has been chief of staff at Harper for three years and now assumes the post of vice president and director of medical affairs.

Doctor Robert Rice leads Health Council

Greenville family physician Robert E. Rice, MD, will lead the Michigan Health Council as president during 1972-73.

Doctor Rice was a recipient of a 1970 MSMS Certificate of Commendation and is nationally known for his leadership in improving health care for rural citizens. He is a member of the AMA Council on Rural Health, past chairman of the MSMS Committee on Rural Medical Service, and has been appointed to three statewide commissions concerned with mental, migrant and rural health.

Other physicians elected to the MHC board include Lionel F. Swan, MD, Detroit, medical advisor; Neal Vanselow, MD, Ann Arbor; Otto K. Engelke, MD, Ann Arbor; Austin Smith, MD, Detroit; and E. Gifford Upjohn, MD, Kalamazoo.

Harry A. Towsley, MD, Ann Arbor, is president emeritus.

Fred J. Hodges, MD, Ann Arbor, left, professor emeritus of radiology, University of Michigan, is the 1972 recipient of the Bruce H. Douglas award of the Michigan TB and Respiratory Disease Association. Doctor Hodges was honored for his pioneering efforts in the use of x-rays in health screening. The award was presented by Walter M. Whitehouse, MD, U-M chairman of radiology.

Jacques S. Gottlieb, MD, Detroit,
chairman, Department of Psychiatry, Wayne State University School of Medicine, and director of the Lafayette Clinic, is the recipient of the 1973 Taylor Manor Hospital Psychiatric Award. The hospital, in Ellicott City, Md., presents the award annually to a physician or scientist in recognition of his contributions to biological psychiatry. Doctor Gottlieb is recognized for his schizophrenia research.

Andrew D. Hunt, Jr., MD, East Lansing,
dean of the MSU College of Human Medicine, has been elected to a one-year term as a member-at-large of the administrative board of the Association of American Medical Colleges Council of Deans.

John C. Peirce, MD, Grand Rapids,
is new chairman of the Scientific Advisory Board of the Kidney Foundation of Michigan. Doctor Peirce is director of the nephrology service at St. Mary's Hospital, Grand Rapids.

Kenneth E. Rowe, MD, Calumet
is new university physician for Michigan Technological University in Houghton. Doctor Rowe, director of the Western Upper Peninsula District Health Department, also serves as medical director of the MTU Student Health Service.

Walter A. Meier, MD, Monroe,
was elected president of the Michigan TB and Respiratory Disease Association, at the association's annual meeting in mid-October. Doctor Meier is director of the Monroe County Health Department and has served as a board member of the MTRDA since 1962.

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Minding your business: Training your aide

By John Steffen
William Ellerthorpe
Lansing

After the doctor has selected the person he wishes for an aide, she must, even though experienced, be oriented in the routine of the office. It is best to decide beforehand what duties she is to perform and to increase her responsibilities as she is ready to cope with them.

When a new aide is replacing another, generally it is wise to have them work together for a period of time to familiarize the new girl with the office routine. By doing this the doctor is relieved of the so-called "breaking in" period. The person doing the training must remember to be patient as the things which are so familiar and seem trivial to her usually are completely new to the trainee. By systematic instruction, the new aide will find it easier to grasp the lesson that is being taught.

Third party payors, namely insurance carriers, Medicare and Medicaid agencies, provide seminars to familiarize the aide in the techniques required to accurately prepare the necessary forms. They will also provide assistance for any special problems she may encounter.

There are many fine schools and courses available to train aides on the technical aspects of a medical office, but individualized training must be done in your own office as no two offices handle everything the same way. Management Consulting Firms familiar with the office can sometimes instruct, guide and arbitrate duties and responsibilities to the employees of the office.

In an office with one employee, the question is simple as to responsibility for doing the work. The problem is one of efficient management of time and application of principles of good office techniques and procedures. When there is more than one employee, it becomes necessary to divide the responsibility. A division as to the business side and the professional side of the office is best. It is easy to see, however, that in many cases there is a dual responsibility; and in others there should be a broad list of responsibilities covering all members of the office, if a satisfactory completion of the job is to be obtained.

One of the first requisites to cooperation is an understanding by all employees as to what each job in the office entails: how it is done, what information is required, and what is the disposition. If all employees are aware of the requirements, much time and effort can be saved in assisting each other in the discharge of their primary responsibilities.

From our understanding and experience, it appears advisable for there to be a definite assigning of responsibility, and an understanding by each employee as to what is expected in the discharge of that responsibility. In addition, the office should be considered a complete unit, and accomplishment of all the work should be the common responsibility of all the employees. The work load of the office should be shared equally where possible. It is recognized that abilities are not equal; however, if the nurse cannot type, she certainly can answer the phone, make appointments, pull and file records, and in other ways assist the business side of the office. Conversely, there are duties which the secretary can do on the professional side when the work load shifts.

To avoid conflicts, a definite understanding as to the duties of primary responsibilities, and the areas of mutual assistance, which can best contribute to a smooth-running office, must be reached.

Encourage suggestions for improvement, have office meetings, be willing to spend extra time working on new ideas, and be willing to give praise when it is called for.

Keeping the channels of communication open is one of the most important things to continuing good office relations.

(This is the second in a series of articles prepared by the Lansing representatives of Professional Management Associates, Inc.)

Advertisement

> *"The history of science, and in particular the history of medicine . . . is . . . the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."*
>
> *—George Sarton, from "The History of Medicine Versus the History of Art"*

Are combination drug products useful in treatment involving concomitant use of two or more drugs?

Opinion

Results of a questionnaire to 7,000 physicians:

62.9%
Believe combination drug products are useful.

13.8%
Do not believe combination drug products are useful.

Are combination drug products useful in treatment involving concomitant use of two or more drugs

Opinion & Dialogue

Doctor of Medicine

Louis Lasagna, M.D.
Professor and Chairman
Department of
Pharmacology & Toxicology
University of Rochester
School of Medicine
and Dentistry

Obviously, many drugs are given concomitantly. Whether it makes sense to combine medications in one preparation, be it capsule, tablet, or liquid, is a question that can be answered only by examining the advantages and disadvantages in the individual case.

Among the advantages is, first of all, convenience. The more medications that are taken concurrently and the more complicated the directions, the less likely the patient is to take medications accurately. From the standpoint of convenience and accuracy, and economy as well, you can make an important case for putting medications together in one preparation, as long as they are compatible.

By the same token, when you prescribe a properly tested and rational combination, you should have less worry about pharmaceutical or pharmacological compatibility – and about reasonable dosage ratios as well. Compatibility of the formulation should be demonstrated in the laboratory and clinic before the product is available for prescription–which is more than can usually be said for the physician's own spontaneous creations. And, the dosage ratios employed in rational precompounded combinations are designed to meet the needs of substantial numbers of "typical" patients.

There is no doubt that many "atypical" patients are to be found, and for them the prefabricated combination must be rejected. But that hardly argues for eliminating rational combinations from the market. Think, for example, of the problems that would arise if the components of widely accepted combinations, like the oral contraceptives and the diuretic-antihypertensives, always had to be prescribed, purchased and ingested separately.

One disadvantage that comes to mind is some doctors' unawareness of the ingredients a given combination contains. For example, a doctor might know that a patient is allergic to aspirin but forget that a certain analgesic mixture, which he knows only by its trade name, contains aspirin. His prescription, then, causes considerable discomfort, to say the least. This problem is a function of physician education, rather than of combination therapy as such. Improving doctors' knowledge about all medicaments they prescribe is a problem that deserves tackling on its own.

Another accusation leveled at combination drugs is that they encourage sloppiness of diagnosis and treatment. In many cases, however, a combination may prove to be the most effective choice. A good example of the usefulness of combinations appears in a recent article in the *Journal of Chronic Diseases* on the efficacy and side effects of an antihypertensive containing three ingredients, in which the track records of the combination drug and the individual ingredients were compared. Interestingly enough, whether the drugs were given individually or together, incidence and severity of side effects were the same. But blood pressure control was invariably better when the drugs were taken in one combination tablet than when they were taken separately (in "titratable" dosage) or in two or three different tablets.

Deciding which combinations constitute rational therapy obviously leads to a discussion of who is to determine which should be used and which should not. Realistically, I think combinations should be evaluated somewhat differently if they are old and established or new and untried.

In today's regulatory atmosphere, there is no possibility of a new combination being put on the market without a substantial amount of acceptable evidence in the form of controlled trials that show it to be safe and efficacious. On the other hand, I believe a different set of standards should apply to combination preparations that have been around for a long time. In other words, physician acceptance over a long period should be given some weight as evidence of the efficacy and safety of these drugs.

The FDA, however, does not seem to share this attitude. It often requires, for these older products, controlled trials that will monopolize the time of already overtired investigators and cost a great de of money. I wish we cou agree on a "grandfath clause" approach to preparations that have been in us for a number of years an that have an apparentl satisfactory track record.

For example, I thi some of the antibiotic co binations that were tak off the market by the FD performed quite well. I a thinking particularly penicillin-streptomyci combinations that patien –especially surgical patients–were given in o injection. This made f less discomfort for the patient, less demand o nurses' time, and fewe opportunities for dosag errors. To take such preparation off the marke doesn't seem to be goo medicine, unless actual usage showed a great deal harm from the injection (rather than the prope use) of the combination.

The point that should b emphasized is that ther are both rational and irrational combinations. Th real question is, who shoul determine which is which Obviously, the FDA mus play a major role in making this determination. I fact, I don't think it ca avoid taking the ultimat responsibility, but it shoul enlist the help of outsid physicians and experts i assessing the evidence an in making the ultimate decision.

Maker of Medicine

W. Clarke Wescoe, M.D.
President
Winthrop Laboratories

If two medications are sed effectively to treat a ertain condition, and it is nown that they are comatible, it clearly is useful nd convenient to provide hem in one dosage form. t would make no sense, in act it would be pedantic, insist they always be rescribed separately. To void the appearance of edantry, the "expert" decries the combination beause it is a fixed dosage orm. When the "expert" nvokes the concept of fixed osage form he obscures he fact that single-ingreient pharmaceutical preprations are also fixed osage forms. By a singular emantic exercise he imlies a pejorative meaning the term "fixed dose" nly when he uses it with espect to combinations. Vhat is ignored is the simle fact that only in the arest of circumstances oes any physician attempt titrate an exact theraeutic response in his paent. It is quite possible hat some aches and pains ill respond to 500 mg. of spirin yet that fact does ot militate against the *usal* dose being 650 mg.

The other semantic ploy ten called into play is to escribe a combination roduct as rational or irraonal.

Take antibiotic mixtures, he source of much of the riticism generated against combinations generally. Obviously, no one should be exposed willy-nilly to the potential side effects of two or three antibiotics when only one is needed. At the same time there are cases where it is prudent to prescribe more than one. The clinician is the judge in these circumstances, as he should be.

There is no clear definition of the word rational. Most persons, I suppose, would find it synonymous with reasonable, but in many circumstances it may best be defined as the opinion of those in power at the moment.

Other factors govern combination therapy, not the least of which has been its broad use by practicing physicians anxious to achieve convenience in prescribing, to reduce medication error, and to save money for their patients. Combinations clearly have met the test on all three counts.

I have been impressed by studies showing that the rate of error climbs markedly with the number of medications to be taken, even with sophisticated patients. When medically justified, therefore, this factor alone supports the logic of combination therapy.

The cost argument for combinations appears to be irrefutable. In 1971, R. A. Gosselin studied the 71 combination products (excluding oral contraceptives) among the 200 most prescribed drugs. The study found that if all 71 products were discontinued, and if each ingredient in these combinations were prescribed separately, the price of medicines to patients would jump by $443.2 million on a national basis! At a time when the cost of medical care is under so much fire, it would be nonsensical to boost costs without clearly irrefutable medical reasons.

The part played by government on this question, of course, is fundamental. The FDA should play a role in determining which combinations are reasonable. That role, as defined by law and regulation, is to ensure that any medication on the market is safe and effective in line with its label claims. Certainly combinations are entitled to as much consideration as single entities—neither more nor less. So long as the addition of one drug to another does not make either less safe, or less effective, so long as they are compatible in a formulation, we have a reasonable product. It makes no sense to recommend the use of two products for certain conditions and to deny their being combined in a single form. An unhappy side effect of the problem concerns the efficacy panel discussions of many products submitted for review. The term "effective, but" has been freely interpreted to mean "ineffective" in toto, regardless of the merit of the individual drugs. This interpretation has placed numerous useful combination products in needless jeopardy.

In reading the actual reports of the review panels, it seems clear that some of the ratings were based less on scientific research and clinical observation than on the "informed" opinions of the panelists. These "informed" opinions were accepted at face value, while the "informed" opinions of others who had used the products were rejected. All of this put combination products into a sort of scientific never-never land.

It should be kept in mind by all, government as well as others involved in our health care system, that advances in therapy are seldom made in leaps and bounds but rather by small painstaking steps—and that some of these steps have resulted from research in combination drugs as well as with single entities. Given the near-infinite biologic variation in patient response, this is hardly surprising to clinicians. It should not be to regulatory agencies either.

In the end, the practicing physician is in the best position to decide if a particular combination makes sense. Such a decision should not be made exclusively by those whose responsibility for continuing clinical care is limited. Clinicians are the best judges of efficacy because the ultimate proof of any product's effectiveness is acceptance by physicians who have observed its actions in patients over time. The corollary statement may be made about over-the-counter medicines, which would not long survive if they failed to afford the relief the user anticipates. That the antihistamine in a "cold" remedy may not *always* be necessary is no reason to proscribe the combination generally.

Opinion & Dialogue

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Figure 1. The first renal transplant in Michigan was performed in 1964 using an identical twin donor. The young ladies involved in the transplant are now nurses and are shown above visiting the first diabetic in Michigan to receive a cadaver renal transplant. The latter was performed at Detroit General Hospital. These patients demonstrate the progress that has been made during the past eight years in broadening the indication of kidney transplantation. (Photo by courtesy of the Detroit News)

Renal transplantation in Michigan

By J. C. Rosenberg, MD, PhD
Detroit

Renal transplantation is a promising and exciting approach to the treatment of end-stage renal disease. It has come a long way from its beginnings as a bold clinical experiment, but many major problems remain unsolved; problems which are scientific, social and logistical in nature.

This review of renal transplantation in Michigan will evaluate the progress that has been made in our state. We will also attempt to define some of the problems which confront us.

Historical perspective[1-3]

Few areas of activity in Medicine can match the rich tradition and colorful history that one finds in the field of transplantation. Replacing diseased organs or tissues with the same part from another human, or from an animal, has been a hope of man for a long time. This is reflected in several Greek and early Christian legends which involve transplant procedures. The legend surrounding Saints Cosmos and Damian, and their replacement of a cancerous limb with one from a cadaver, has become the traditional starting point of many presentations on transplantation. During the Renaissance, Tagliacozzi (1596) kept this hope alive by showing how autogenous tissue could be used to correct cosmetic defects of the face.

The modern era of research in transplantation began during the early part of the 19th Century and culminated in the successful use of skin autografts by Reverdin, Ollier, Thiersch and others. At the beginning of the present century it was appreciated that the problems of transplanting tissues from one person to another and across species barriers was more complex than autografts. Schöne, in 1912, utilized the term, "Transplantationsimmunität" to characterize the process of rejection.

A major technical problem confronting organ transplantation was also solved at the beginning of the 20th Century. Carrel and Guthrie perfected vascular anastomotic technics and stimulated a great deal of work in renal transplantation. However, all of these efforts were exercises in futility. Without an understanding of the immunologic basis of the rejection reaction, provided by Medarwar's Nobel-prize winning investigations (1943-1947), there was little chance of success.

In 1902 Ullman, in Vienna, reported upon his laboratory and clinical experiences in renal transplantation. Jaboulay (1906) and Unger (1910) made similar attempts to transplant kidneys from a variety of species to uremic patients; all with the same unsuccessful results.

The use of human cadavers as donors was first reported by the Russian, Voronoy (1936). Nine years later, the Peter Bent Brigham Hospital group, one which was to make many contributions to the field of clinical renal transplantation, attempted cadaver kidney transplant. Stimulated by Dr. G. Thorn, Professor of Medicine, Hufnagel, Landsteiner and Hume transplanted a kidney to a young woman with renal failure secondary to postpartum sepsis. The details of this procedure can be found in Moore's book, *Give and Take.*[2] It is a fascinating account which

Scientific articles

Doctor Rosenberg is Professor of Surgery at Wayne State University School of Medicine. His paper was presented at the Eleventh Annual Kidney Disease Symposium of the Kidney Foundation of Michigan, May 19, in Detroit.

merits reading by those interested in the beginnings of renal transplantation.

Subsequent to these attempts at treating renal failure with kidneys from cadavers and animals, the use of hemodialysis and peritoneal dialysis became popular. Dialysis was employed by many centers but, again, the Brigham Hospital was among the most active. It is therefore understandable that a Brigham surgeon, Doctor David Hume, a native of Muskegon, who had participated in the earlier procedure with Hufnagel and Landsteiner, would want to explore cadaver renal transplantation in a more systematic fashion than had previously been done. This project began in 1951, the same year that several French investigators launched similar studies. During this period, experimental work was actively being pursued by others, notably Dempster in London and Simonsen in Copenhagen. Although some progress was made, there was little success to point to, largely because of the obstacle presented by the homograft rejection reaction.

Two approaches were then developed to circumvent the problem of rejection of transplanted organs. In 1954, transplantation between identical twins was successfully accomplished and in 1958 total body irradiation was used as a means of immunosuppression. The former procedure was successful; the latter proved to be too drastic as a means of preventing rejection.

Chemical agents were introduced to provide immunosuppression in 1959. By 1961, azathioprine was developed and, along with steroids, became basic immunosuppressive therapy for all renal transplants.

Three years later, the first renal transplant in Michigan was performed.

Michigan renal transplant programs

University of Michigan[4]

The first kidney transplant in Michigan was performed in Ann Arbor in March, 1964. The donor and recipient were 15 year old identical twins. These girls subsequently graduated from nursing school and recently celebrated their eighth post-operative anniversary. **(Figure 1)** From 1964 to 1967, the transplantation program of the University of Michigan was the only one in the state. A total of 25 kidneys were transplanted during this period. Initially, only living donors were employed but in February of 1965, the first cadaver transplantation was performed. In 1967 a tissue typing laboratory was established and a great deal of excellent clinical and laboratory research in the use of immunosuppressive regimens was developed.

Henry Ford Hospital[5]

In January, 1968, a renal transplantation program was initiated at the Henry Ford Hospital in Detroit. The following year, tissue typing was instituted and experimental studies in renal preservation were begun. Both cadaver and living donors have been used.

Wayne State University

Detroit General Hospital, Hutzel Hospital and Childrens Hospital of Michigan are the affiliated hospitals of Wayne State University where renal transplants are performed. The program was initiated in May, 1968 at Detroit General Hospital. Comprehensive histocompatibility and transplantation laboratory facilities were organized in 1969. Preservation of human kidneys by perfusion technics was begun in March, 1970, representing the first effort in Michigan at long-term clinical renal preservation. In addition to these activities, research has been carried out in mechanisms of rejection and effects of immunosuppression.

Hurley Hospital[6]

A cadaver renal transplant was performed in January, 1971 at Hurley Hospital in Flint, followed by another transplant in 1972. Plans are currently under way to expand the program to include living donors.

Borgess Hospital[7]

In November, 1971 a kidney transplant was performed at Borgess Hospital in Kalamazoo. By the end of the year a total of 3 had been carried out. As of May, 1972 a total of 10 transplants had been done. Efforts have also been made to provide for preservation of cadaver kidneys. The program in this area of the state is very active and includes both living and cadaver renal transplants.

William Beaumont Hospital[8]

The most recently established transplant program in Michigan is the one initiated at William Beaumont Hospital in Royal Oak. A living donor transplant was carried out in February of 1972. A second transplant has been performed, others are planned and several patients are awaiting a suitable cadaver donor kidney.

Michigan agencies concerned with renal transplantation

Kidney Foundation of Michigan

Appropriate to its purposes, the Kidney Foundation of Michigan has been a pioneer in bringing renal transplantation services to the State of

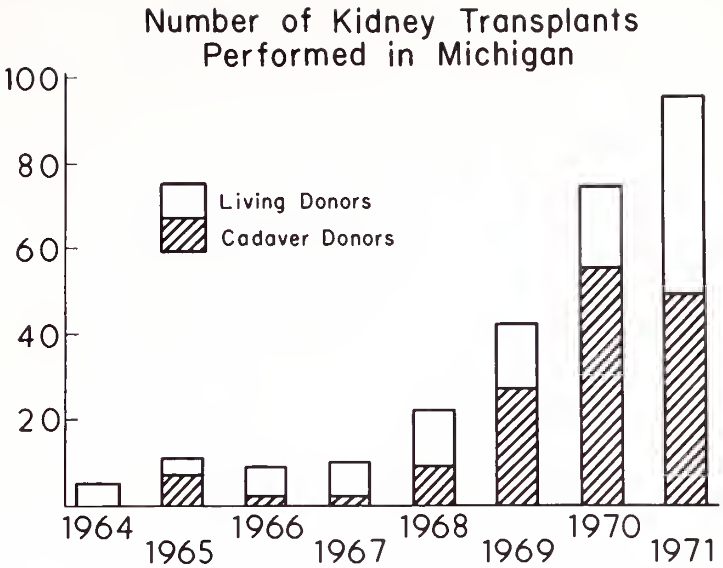

Figure 2. Number of kidney transplants performed in Michigan since 1964 when the first such procedure was carried out.

Michigan. This society was originally founded in 1955 by a group of concerned physicians and parents who wished to do something about nephrosis and its occasionally devastating effects on children. The group grew into an aggressive health service agency which is now national in scope. The Kidney Foundation of Michigan is the largest affiliate of the National Kidney Foundation and does more than any other similar state organization in providing direct services and support of research for kidney diseases.

In the realm of renal transplantation, the Kidney Foundation of Michigan established a "drug bank" for transplant patients in 1965. They provide drugs at no cost to the recipients of renal transplants. In 1966, the Foundation established the first walking kidney donor bank. Donation of kidneys after death was encouraged to help meet the need for cadaver organs. In 1969 the Kidney Foundation of Michigan vigorously supported the enactment of the Uniform Anatomical Gift Act by the state legislature and has continuously urged appropriation of funds to support all modalities of treating kidney disease.

Michigan Department of Public Health

Activity by the State of Michigan in the area of renal transplantation has recently increased appreciably. The Bureau of Health Facilities has compiled a publication, *Minimal Criteria and Guidelines: Kidney Transplantation Services,* which should facilitate proper planning of renal transplant centers. The Department of Public Health has also begun to support programs for sharing the kidneys among the transplantation units. This should be of great benefit to those patients who must wait many months before receiving a cadaver renal transplant.

The Department of Public Health, in cooperation with the Kidney Foundation of Michigan, has also sponsored the creation of a renal disease registry. The registry includes patients with renal transplants and should be able to provide essential data on the scope of the problem in Michigan.

In viewing the distribution of current renal transplant units, (Figure 3) one finds that they correspond to the population density within the state. If one draws a line across the middle of the lower peninsula (at the level of the tip of the "thumb") approximately 600,000 people will be found to live north of this imaginary line and 8,000,000 reside south of it. More than 4,000,000 live in the Detroit area. Thus there is justification for many of the present locations of the kidney transplant centers.

Estimates have been made that an integrated dialysis and transplantation patient-care system should be organized so that a dialysis facility would serve a population of 500,000 persons and a transplantation program should service a population of three to four million.

Current and future needs with respect to renal transplantation

What is most urgently required is an overall plan for the management of kidney disease in Michigan so that a reasonable and acceptable pattern of patient referral for renal transplantation can be established. The centers which will assume the responsibility of providing this highly specialized level of care must be adequately supported and funded. Duplication of services and competition among institutions must be avoided.

Communication and cooperation among the transplantation centers and with referring physicians and hospitals, must be established and kept functioning.

Vigorous efforts to educate the public and the profession on the need for cadaver organs is imperative. A network should be formed to salvage kidneys and arrange for their distribution based on need and best chance of success.

Efforts such as the Donor Card program of the Kidney Foundation deserve wider support. The Ninth Report of the Human Renal Transplant Registry indicates that in 1970, close to 70% of all of the kidneys transplanted came from cadaver sources.[9] The need to pursue a more productive procurement program is the most pressing need in Michigan's current kidney transplantation programs.

Transplantation Society of Michigan

This newly formed group has arisen in response to a need within the State for greater cooperation and sharing of resources and facilities in the field of transplantation. Most urgent is a wider availability of cadaver kidneys. Preservation of kidneys has progressed to the point that it is most reasonable to transport donor organs from one end of the state to the next; depending on where the greatest need and the best chance of success is. The Transplantation Society has worked closely with the Kidney Foundation of Michigan, the Michigan Department of Public Health and the existing transplantation centers. It is hoped that their programs will increase and improve the renal transplantation services in the State of Michigan.

Planning for the future

Transplantation as a component in an overall plan for the management of renal disease in Michigan

Undertaking a kidney transplant program demands a major commitment by the institution involved. Full-time health care professionals (medical and para-medical) must be prepared to devote most of their efforts to this program. It is also important that the transplant program be integrated into an overall plan for the management of renal disease in that region. The existence of a dialysis unit within a hospital does not in itself constitute sufficient support for a transplant program. A commitment to support a renal transplant program must be regional as well as institutional. Regional commitment entails affiliations with home dialysis facilities and ambulatory or satellite maintenance dialysis units. In order for the program to be effective, the renal transplant center should receive referrals from groups whose capabilities, although sophisticated, do not include the full range of services that one finds at a highly specialized center. Many multispecialty clinics and hospitals may be able to diagnose and manage most problems accompanying end-stage renal disease but do not see the volume of patients that would justify establishing the special diagnostic and immunologic services required for a renal transplant program. Such clinics and hospitals should be closely allied with a transplant center.

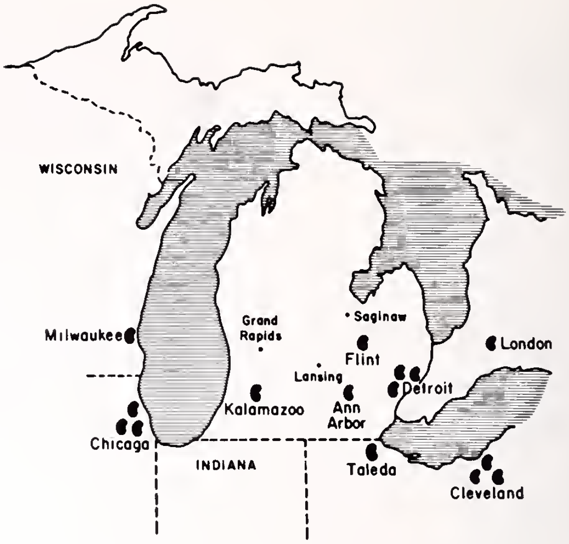

Figure 3. Each figure of a kidney in the above illustration represents a hospital that has done at least one kidney transplant.

Kidney transplantation must also be viewed as a mode of therapy that is still being perfected. There must be a strong element of investigation involved in each procedure to learn how to improve the delivery of this form of treatment. Much that is learned can be used in other areas of health care, e.g., immunologic diseases and transplantation of other organs.

Number and distribution of transplant centers for Michigan

The Gottshalk Report estimates that for every million people in the United States, 35 will develop end-stage renal disease per year. Of these patients, it is estimated that 20 to 25 will be best treated by transplantation and the remainder by home or in-center dialysis. Michigan has a population of 8.6 million people. Thus, it can be expected that 170 to 200 renal transplants will have to be performed yearly in Michigan. As can be seen in Figure 2 we have not yet met this need but have improved each year. If one allows that at least 30 to 50 kidney transplants a year constitutes a minimum that any center should perform in order to remain competent and justify the investment of maintaining a rental transplant program, it would appear that Michigan

Perinatal tips

By Paul M. Zavell, MD
Detroit

The following case from the files of the Wayne County Medical Society Perinatal Mortality Study Committee is presented as an aid in continuing education.

Maternal

This was the first-born of a 42-year-old white woman. The mother was a gravida 1, para 0 (1), with A positive blood type.

After five years of marriage and failure to become pregnant, the parents adopted first an infant boy and then, a year later, an infant girl. As happens so often, shortly after the adoption of the second child the mother became pregnant for the first time.

This pregnancy was complicated in the first two months with frequent morning nausea and vomiting. The mother was given some "pills" by her obstetrician (we do not know what they were) that controlled most of her symptoms.

At 34 weeks of her pregnancy the membranes ruptured spontaneously with a sudden gush of bloody-tinged fuild. This stopped within a few minutes and she did not go into labor.

She was seen by her obstetrician who after a sterile vaginal examination felt observation in the hospital was in order. After admission to the hospital no further leakage of fluid occurred and fetal heart tones were strong (140-160/min.). Routine CBC and urinalysis were normal and she remained afebrile.

After 48 hours of observation she was discharged home. For the next three weeks no more amniotic fluid leakage was noted and her pregnancy seemed uneventful.

At 37-38 weeks she caught a severe "chest cold" treated with Benylin Expectorant, aspirin and Ampicillin 250 milligrams qid.

Labor began shortly thereafter and she was readmitted to the hospital. Despite her age, this being her first pregnancy and despite the severe URI it was felt she should deliver vaginally. However, after 20 hours and 34 minutes of so-so labor (good for the first 12 hours and poor thereafter) a C-Section was performed resulting in a four pound, 10 oz. white male infant.

The mother ran a temperature of 101-102 for three days after surgery with intermittent coughing but no other complications. Chest x-ray failed to reveal pneumonia. Other studies were: 1) CBC of: Hgb = 11.5 gms., WBC = 9,500, PMN = 58, Bd = 02, Mono = 01, Lymph = 38, Eos = 01. 2) Urinalysis = yellow, straw, 1.018, negative for albumin, sugar, acetone, and microscopic, and 3) VDRL neg.

Fetal

This four pound, 10 oz. male infant had an apgar of 6 at one minute (poor muscle tone, slow to breath and pale color) and 8 at five minutes. With oxygen, mist, and an isolette color improved but rapid shallow respiration of 60-100/min. persisted for several hours after birth. Physical examination failed to reveal anything else unusual and chest x-ray only showed "fetal atelectasis." Because of the mother's history, blood and pharyngeal cultures were done. By 12 hours of age respirations had become 20-40/min. and not labored but infant appeared a little irritable when both-

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Doctor Zavell is chairman, Neo-Natal and Hospital Care Commitee, Michigan Chapter, A.A.P., and chairman, Perinatal Mortality Study Committee, Wayne County Medical Society.

RENAL TRANSPLANTATION/Continued

requires 3 to 6 centers in order to provide renal transplantation to those that require it. Sufficient talent and resources exist within the state to meet this need.

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ered and sucked only with encouragement. However, Karo water was taken fairly well but slowly by nipple. Temperature ranged 99-100° (R).

After the first 12 to 24 hours of age he had no further respiratory problem and gradually was weaned to open air. At 48 hours of age the throat culture was reported back as showing E. Coli but the blood culture was negative. These results were felt to be unimportant and no therapy was given.

A repeat chest x-ray was done on the fourth day of life and was entirely normal. Thereafter his course was almost uneventful except that he spit up or vomited three to four times each 24 hours and remained at times irritable. This was thought to be due to his age and the feeding technique.

At 17 days of age and weighing four pounds, 14 ounces he began to have forceful vomiting with each feeding. Physical examination failed to reveal anything unusual. Chest, upper GI and flat plate x-rays were done. An intravenous of 5% G/W with 0.3 N/S was started and he was taken to the operating room where an operation was done. At operation a pyloric tumor was found and this was corrected by a classical Ramstedt procedure.

Perinatal Committee Comments

1. The Committee feels that an elderly primipara (here 42 years old) is a candidate for early C-Section when good labor fails to show progressively satisfactory resolution. Twenty-plus hours as in this case seems a little long.
2. More and more recent pediatric literature stresses the danger to the infant when mother is given medications during pregnancy (especially before delivery). Aspirin and antihistamines may carry increased risks.
3. The procuring of cultures in the infant when he showed initial respiratory, sucking and lethargic problems is commended. However, until results are known it is wise to treat the infant with antibiotics as if he is a suspect sepsis rather than just to observe the infant.
4. It is noted that despite the onset of forceful vomiting physical exam failed to reveal the pyloric tumor found at operation. Admittedly it is difficult at times to feel this tumor but one can increase his chances of so doing if the abdomen is palpated after first emptying the stomach by gavage or immediately following a vomiting episode.

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

Monthly Surveillance Report

CASES OF CERTAIN DISEASES
REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH
For the five-week period ending Dec. 1, 1972

	1972 This 5-week Period	1971 Same 5-week Period	1972 Total To above Date	1971 Total Same Date	Total Cases for 1971
Rubella	76	102	1,389	2,871	2,955
Congenital Rubella Syndrome	1	0	1	1	1
Measles	204	172	2,242	2,599	2,659
Whooping Cough	9	11	109	135	140
Diphtheria	0	0	1	0	1
Mumps	372	471	3,258	10,220	10,748
Scarlet Fever & Strep Sore Throat	1,814	1,124	11,322	10,239	11,244
Tetanus	1	1	2	3	7
Poliomyelitis (paralytic)	0	0	0	0	0
Hepatitis	412	474	3,986	4,481	4,828
Salmonellosis (other than S. typhi)	67	80	746	650	691
Typhoid Fever (S. typhi)	0	3	7	10	10
Shigellosis	47	40	538	237	295
Aseptic Meningitis	45	27	246	218	239
Encephalitis	20	8	102	101	108
Meningococcic Meningitis	10	3	54	60	64
H. Influenza Meningitis	9	12	73	79	82
Tuberculosis	123	157	1,521	1,730	1,824
Syphilis	449	559	4,452	4,234	4,689
Gonorrhea	2,692	2,521	22,674	20,435	22,115

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, M.D., Director
Michigan Department of Public Health

Primary amyloidosis of the renal pelvis: A case report and review of literature

By Alexander S. Ullmann, MD, LMCC
Rochester

Primary amyloidosis of the urinary tract in the absence of renal parenchymal involvement is an unusual occurrence. Primary amyloid deposits have been described in the urethra,[1] urinary bladder,[2,3] ureter,[4] and renal pelvis. Amyloidosis localized to the pelvicaliceal system is quite rare, only six cases having been reported.[5-9]

Case Report

A fifty-eight year old white female, No. 39509, was admitted to Crittenton Hospital in November 1971, for investigation of hematuria and sudden onset of severe left flank pain associated with nausea and vomiting. There was no history of allergies, tuberculosis, malignancy, rheumatic fever, or syphilis. She had been diabetic for twelve years, taking Protamine Zinc insulin daily. In 1960 she passed renal calculi. She has had multiple episodes of painless hematuria associated with dysuria since 1969. In March 1970, cystoscopic examination revealed the presence of a red hemorrhagic area. Tissue biopsy showed only slight submucosal lymphocytic inflitration. No amyloid was present in the biopsy material. Retrograde pyelographic study demonstrated normal-appearing right collecting structures and ureter. On the left side, the renal pelvis appeared constricted as did its major infundibula. The narrowing of these structures had a moderately coarse, nodular appearance. The ureteropelvic junction, the renal pelvis, and the majority of the infundibula failed to distend despite the use of an adequate amount of contrast material. While the middle and minor lower calices were quite well filled and appeared normally cupped, the superior pole infundibular constriction apparently prevented complete filling of the minor collecting structures. A very limited fine scalloping of the upper ureteral margins was barely perceptible. Culture of the urine revealed rare diphtheroid species, the colony count being less than 10,000 bacteria per cubic centimeter of urine. Upper GI series and barium enema were essentially negative.

Repeat cystoscopic examinations performed in July and October 1970 and March 1971, for continued episodes of dysuria and hematuria showed inflamed areas suggestive of hemorrhagic cystitis. No tumor, diverticula, or foreign bodies were noted in the bladder. Biopsy of the bladder in October 1970 showed heavy infiltration of the wall by lymphocytes, plasma cells, and occasional segmented neutrophils. Again no amyloid was seen. Multiple urinalyses revealed 5 to 10 white blood cells and occasional red blood cells per high power field, and on one occasion 3+ sugar without acetone. Bacteriologic examinations of the urine were consistently negative, including cultures for acid fast bacilli, fungi, and Neisseria.

Sequential pyelographic studies performed at the same intervals showed a slow, steady progression of the filling defects in the left infundibula, renal pelvis, and upper ureter with the pattern slowly changing from one of moderately coarse nodular defects to a gradually more extensive, irregular constriction of these segments. Several intravenous urograms revealed good excretory function bilaterally. The renal parenchyma visible in the nephrographic phase of these studies has been consistently unremarkable, and these examinations served merely to confirm the irregular diffuse filling defects described above.

Physical examination on her last admission was essentially non-contributory. The blood pressure was 120/80, pulse 75 per minute, temperature 98.4 F.

Laboratory examination showed cloudy urine containing 2+ albumin, 2+ glucose, and innumerable red blood cells, 14.6 gm. hemoglobin, 6.3 white blood cells per cu. mm. with normal differential count and non-reactive VDRL test. Blood urea nitrogen, calcium, phosphorus, uric acid, and the electrolytes were within normal limits. Fasting blood sugar determinations varied between 120 and 410 mg. per cent. Sedimentation rate was 29 mm. per hour. Urine culture was negative for acid fast bacilli, but showed a few coliform bacteria, the colony count being 2,000 per cu. cm. Bence-Jones protein could not be demonstrated in the urine. Serum protein electrophoresis showed 5.52 gm. per cent protein, with 3.18 gm. albumin, 0.26 gm. alpha I globulin, 0.91 gm. alpha II globulin, 0.75 gm. beta globulin, and 0.42 gm. gamma globulin. The Sia test was negative. Class S19 macroglobulins were 3.3 per cent of the total protein. No cryoglobulins were present in the serum. Immunoglobulin assay revealed 1350 mg. per cent of IgG, 120 mg. per

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Doctor Ullmann is Chief, Department of Pathology, Crittenton Hospital in Rochester.

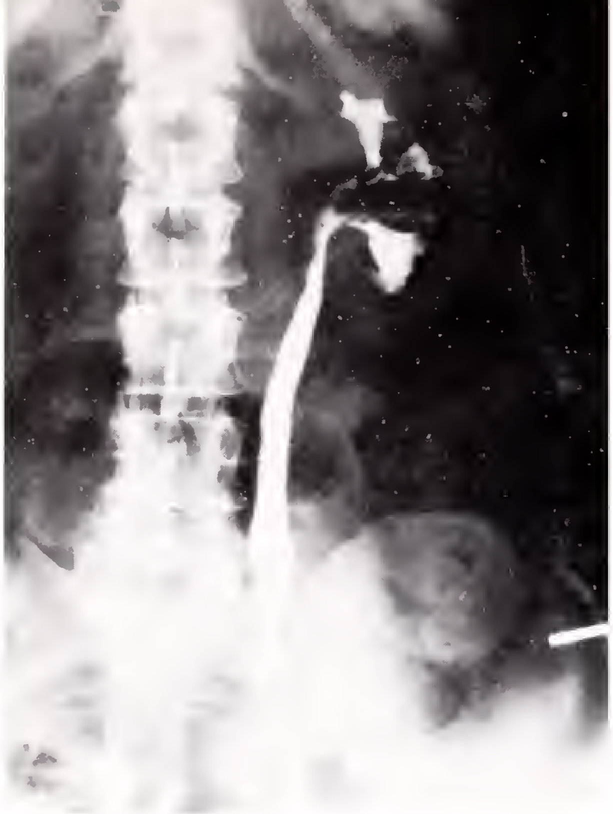

Fig. 1. A, IVP demonstrates the filling defects in the left infundibula, renal pelvis and upper ureter.

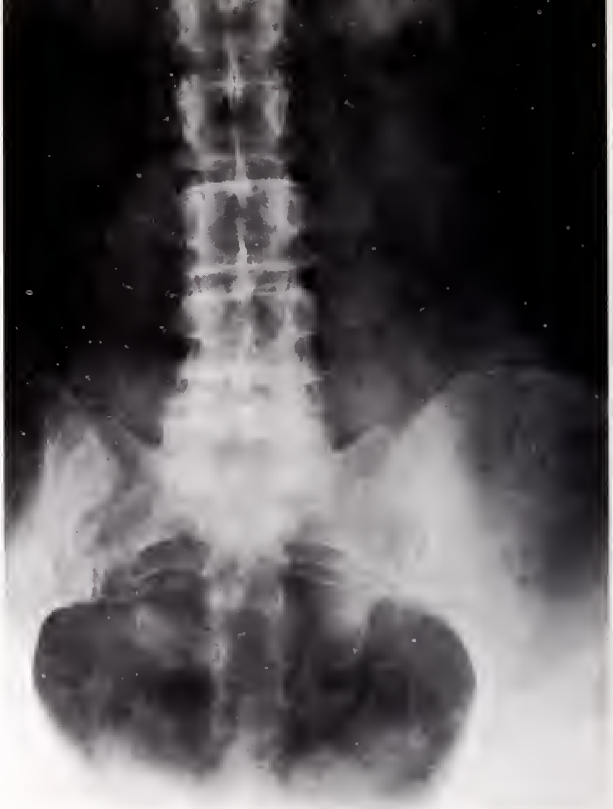

Fig. 1. B, No calcification is visible on flat plate of abdomen.

cent of IgA, 175 mg. per cent of IgM, and 7 mg. per cent of IgD (all within normal limits).

The sternal bone marrow was normocellular. The myeloid-erythroid ratio was 1.5:1. The cellular elements were present in their usual proportion, and no plasmacytosis was noted.

Cystoscopic examination showed evidence of subsiding hemorrhagic cystitis. Catheter urine from the left kidney was reported to contain occasional atypical cells but it could not be determined whether the cellular changes were due to inflammation or low grade malignancy of the pelvic epithelium. The retrograde pyelogram was essentially similar to the previous one. In addition, it now showed definite nodular scalloping of the entire upper half of the ureter but without significant constriction of its lumen. At no time during the progression of this lesion had there been any calcification visible in the upper urinary tract **(Fig. 1 A and B)**. Chest x-ray and a skeletal survey study were within normal limits. There was no evidence of lytic or blastic lesions in the bones.

Two weeks following admission the left kidney was explored. A large amount of granular material was removed from the pelvis. This homogeneous acellular material was not identified on frozen section. Brisk renal bleeding prevented further attempt at renal biopsy, and the kidney was removed together with the proximal portion of the ureter. The kidney measured 11 x 6 x 5 cms. and weighed 180 grams, and it had 16 cm. of ureter attached. The renal parenchyma was relatively pale. The mucosa of the major calices, renal pelvis, and of the proximal 10 cm. of the ureter was blood-stained, rusty brown, and appeared finely granular. Most of the minor calices contained clotted blood. The pelvic wall and the affected portion of the ureter measured 3 mm. in thickness.

Microscopic examination: Sections of the calices and renal pelvis revealed extensive submucosal deposits of an amorphous homogeneous acellular material that stained pink with the hematoxilin and eosin stain **(Fig. 2)**. The walls of the blood vessels in these areas were thickened and stained homogeneously with eosin **(Fig. 3)**. Crystal violet and Congo red stains colored these areas and the vessel walls metachromatically and pale brown, respectively, while the periodic acid Schiff stain was weakly positive in focal areas. The material was partially birefringent on Congo red stain. There were collections of lymphocytes and a few scattered plasma cells between the deposits. The transitional epithelial cell lining was preserved in some areas, particularly in and near the calices, where the cells appeared somewhat piled and distorted, but in most areas the epithelium was almost entirely lost and the amyloid deposits lay freely on the surface. The proximal portion of the ureter showed similar extensive subepithelial amyloid deposits **(Fig. 4)**. No amyloid was detected in the kidney parenchyma.

Recovery from surgery was uneventful. Gingi-

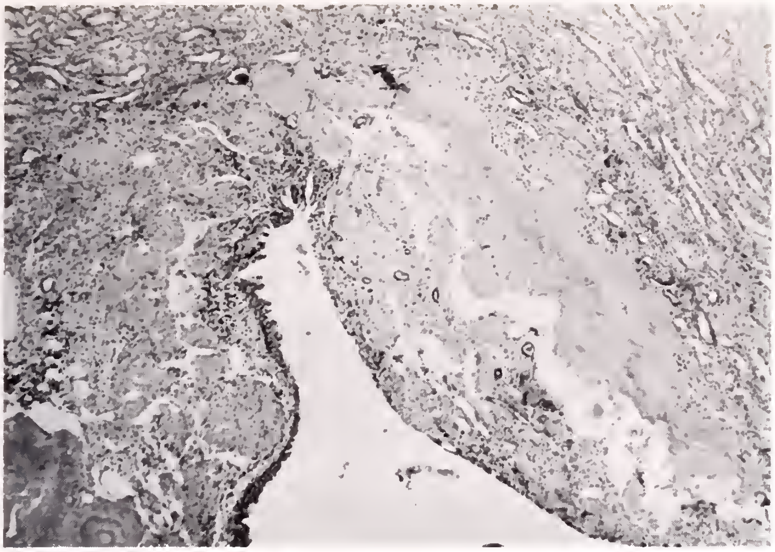

Fig. 2. Extensive submucosal amyloid deposits around a calix. Transitional cell epithelium is preserved on the left. H and E, x 120.

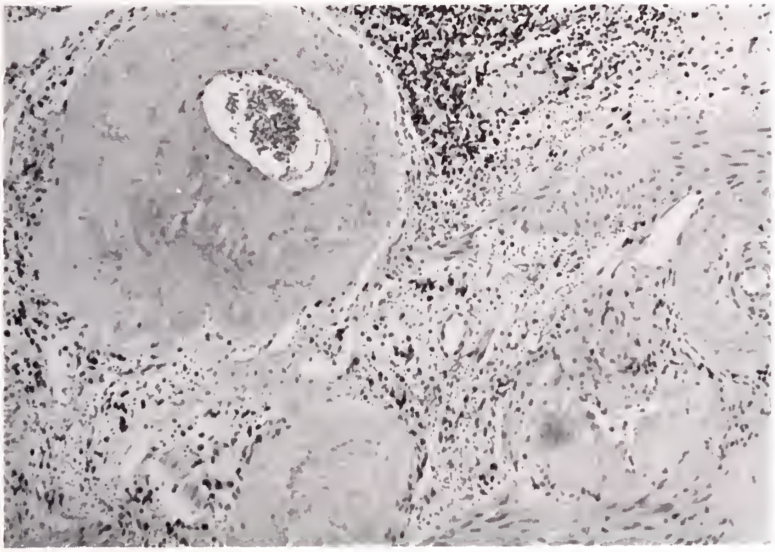

Fig. 3. Amyloid in the wall of an artery in the renal pelvis. Heavy mononuclear inflammatory cell infiltration in the surrounding tissue. Congo red stain, x 400.

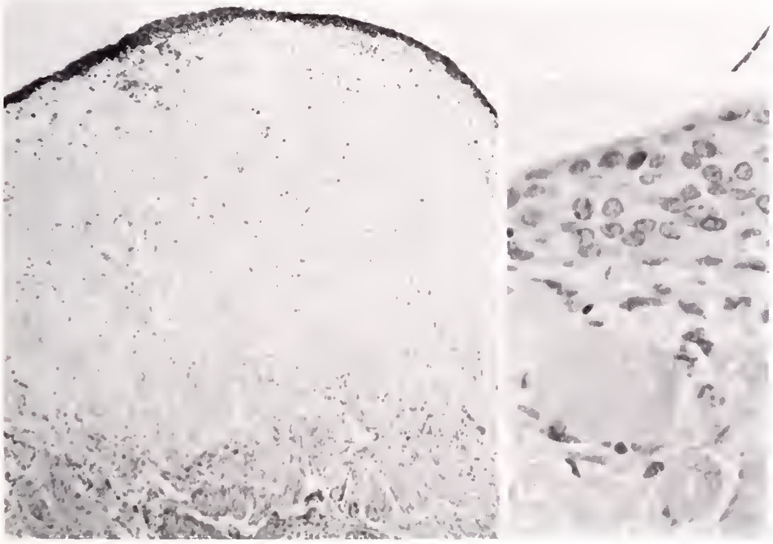

Fig. 4. One of the few areas of the proximal ureter where the epithelium is still preserved. Note marked thickening of the wall. H and E, x 120. (Insert: x 800).

val and rectal biopsies performed at a later date showed no evidence of amyloidosis.

Discussion

The term primary localized amyloidosis indicates the deposition of a homogeneous, eosinophilic, glassy hyalin material in various tissues, without evidence of systemic involvement, predisposing factors, or apparent cause.

Primary amyloidosis localized to the renal pelvis presents a great diagnostic challenge. In none of the seven reported cases, including the present one, was the diagnosis known or even suspected pre-operatively. In three patients, the diagnosis was made on biopsy material after exploration of the kidney,[8,9] in three on examining the nephrectomy specimen,[6,7] and in one case at autopsy only.[5] Concurrent involvement of the ureteropelvic junction or of the proximal portion of the ureter was demonstrated in six cases.[6-9] One patient, on whom the diagnosis of primary amyloidosis of the right renal pelvis was made after surgery, died shortly thereafter, and the autopsy revealed bilateral pelvicaliceal involvement.[8] In three previous cases there was no radiographic evidence of calcium deposits in the renal pelvis. The lesions caused filling defects and appeared tumor-like.[5-7]

Chisholm and his associates observed calcifications radiologically in two patients.[8] In their Case 2 the calcified amyloid deposit closely resembled, and was radiologically indistinguishable from a staghorn calculus. In their other patient, however, there were well developed punctate patches of calcifications present in both kidneys outlining the renal pelvis. Gardner and his associates demonstrated a strikingly similar linear accumulation of calcium along the renal pelvis.[9] In their patient the distribution of the calcium was submucosal, and intravenous pyelography disclosed a radiolucent band, representing mucosa, between the calcium and contrast medium. They considered this unusual radiologic sign pathognomonic.

In our case, the lesion appeared on a series of retrograde and intravenous pyelograms taken over a period of 20 months, as gradually progressing filling defects in the infundibula, renal pelvis, and upper ureter. No calcification was seen on any of the films. It seems reasonable to assume that, while Gardner's radiologic sign, when present, might be useful in suggesting amyloidosis, some cases will not show calcifications, and their absence cannot rule out the diagnosis.

The diagnosis of primary localized amyloid deposit at any site must depend partly on ruling out the existence of predisposing factors and the possibility that it is only local manifestation of a diffuse systemic involvement. In the present case no underlying disease was discovered during the 20 months in which the patient was under medical care, in spite of careful clinical evaluation and laboratory studies. The literature does not reveal a single case of secondary amyloidosis of the renal pelvis in the absence of renal parenchymal involvement.

Plasmacytosis and abnormal serum protein electrophoretic pattern have been reported in several cases of primary urinary tract amyloidosis.[1,8] The laboratory studies of this patient prove that even extensive localized amyloidosis may exist without producing immunologic changes perceptible by present-day laboratory methods.

Summary

A case of primary amyloidosis of the renal pelvis is reported and the literature has been reviewed for similar cases. The lesion presented itself on x-ray as a large filling defect resembling a tumor. Laboratory studies including cytologic examination of the urine, serum protein electrophoresis, immunoglobulin assay, and examination of the bone marrow were not helpful in arriving at the diagnosis. Calcifications demonstrated radiologically in some previous cases and considered to be pathognomonic, when present, were not seen in this patient.

The author is indebted to the attending physicians W. H. Dickerson, MD, and R. Drew, MD, for their kind cooperation, and to C. A. Tressler, MD, for his help in reviewing and interpreting the radiologic material.

Abstract

Primary amyloidosis localized to the pelvicaliceal system in the absence of renal parenchymal involvement is an unusual occurrence.

The six cases previously described in the literature are reviewed, discussed and a new one is reported. The diagnosis was not known or even suspected preoperatively in any of the cases. In three patients the diagnosis was made on biopsy material after exploration of the kidney, in three on examining the nephrectomy specimen, in one at autopsy only.

In the present case, the lesion appeared as gradually progressing tumor-like filling defects in the infundibula, renal pelvis, and upper ureter on a series of retrograde intravenous pyelograms taken over a period of twenty months. Calcifications demonstrated radiologically in some previous patients and considered to be pathogno-

Drug therapy problems

By Louis Depping, RPh
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Q. When spironolactone is given to a patient who is receiving a thiazide diuretic with a potassium supplement, should the potassium supplement be discontinued? M.J., A.A.

A. *In general, it is unnecessary to give a potassium supplement to patients receiving thiazides and spironolactone. However, if the patient has some potassium depletion, the potassium supplement may be continued for several days until the serum potassium returns to normal. If the potassium level is elevated and the patient has some degree of renal failure, there is the risk of hyperkalemia developing and the potassium supplement should be discontinued immediately.*

Q. Will Tums^{R} interfere with the absorption of iron? C.D., A.A.

A. *Antacids such as calcium carbonate, aluminum hydroxide and magnesium hydroxide decrease absorption of iron. The mechanism of this interaction has not been established. It has been suggested that spacing of the doses of antacid and iron preparation may be useful in the management of this interaction.*

Q. Can diphenylhydantoin (Dilantin^{R}) be given by the intravenous drip method of administration? C.A., A.A.

A. *Dilantin^{R} is supplied with a special solvent of propylene glycol 40% and alcohol 10% in Water for Injection. If the solution is diluted with any other fluid the Dilantin^{R} may precipitate. Therefore, Dilantin^{R} should be given orally, intramuscularly or by I.V. push.*

Q. What is the relative potency of methylprednisolone, prednisone and hydrocortisone? D.S., A.A.

A. *Hydrocortisone, 20 mg. is equivalent to methylprednisolone 4 mg. and prednisone 5 mg.*

Q. What is the preservative in Lipo-Heparin^{R}? D.T., A.A.

A. *Benzyl alcohol 0.9%.*

Q. Are Vi-Cert^{R} and hydrocortisone sodium succinate (Solu-Cortef^{R}) compatible in intravenous solution of Dextrose 5% and water? A.C., A.A.

A. *Initially the mixture appears compatible in D5W. The acidic pH of this combination may eventually result in hydrolysis of the hydrocortisone salt. Incompatibility will depend upon concentration of additives and time. Up to four hours may be necessary to see the incompatibility.*

Mr. Depping is associated with the Drug Information Center, University Hospital, Ann Arbor, 48104.

AMYLOIDOSIS/Continued

monic, when present, were not seen in this case. Biopsy of gingiva, rectum, and bladder were negative for amyloid. Laboratory studies including cytologic examination of the urine, serum protein electrophoresis, immunoglobulin assay, and examination of the bone marrow were not helpful in arriving at the diagnosis.

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1973 Conference on Maternal Health

March 21 - 22

Plans are nearly complete for the Annual Michigan Conference on Maternal and Perinatal Health which will be presented by MSMS March 21-22 at the Olds Plaza Hotel, Lansing.

Preceding the first session on Wednesday afternoon, the 21st, a meeting has been arranged by the Nurses Association of the American College of Obstetricians and Gynecologists.

Highlights of the program are as follows:

Wednesday, March 21

1:30-3 p.m. First Session, "Divergent concepts in the management of breech presentation," with Thomas H. Kirschbaum, MD, East Lansing, moderator

Participants: Joseph J. Woods, MD, Detroit, president, Michigan Society of Obstetricians and Gynecologists
Jack M. Schneider, MD, Madison, Wis., director, Division of Fetal and Perinatal Medicine, University of Wisconsin
Brooks Ranney, MD, Yankton, S.D., chairman, Department of Obstetrics-Gynecology, Univerversity of South Dakota School of Medicine, The Yankton Clinic
William C. Witting, MD, Ann Arbor

3:30-5 p.m. Second session, "Do backward babies make good parents?" with Thomas A. Helmrath, MD, East Lansing, moderator

Participants: Roland L. Poland, MD, Detroit, assistant professor of pediatrics, Wayne State University School of Medicine, Michigan Children's Hospital
Paul F. Muller, MD, Indianapolis

7 p.m. Annual Banquet, with Gordon Deckert, MD, Oklahoma City, author of best-selling book, "I'm OK, You're OK"

Thursday, March 22

9 a.m. Third session, "Induction of Labor," with Lee B. Stevenson, MD, Farmington, moderator

Participants: William C. Witting, MD, Ann Arbor
Jack M. Schneider, MD, Madison, Wis.

10:45 a.m. to 12:30 p.m. Fourth Session, with William B. Weil, MD East Lansing, moderator

Participants: Ronald E. Myers, MD, Bethesda, MD, chief, laboratory of Perinatal Physiology, National Institute of Neurological Diseases and Stroke

Albert Sparrow, MD, East Lansing, pediatric cardiologist, Department of Human Development, Michigan State University College of Human Medicine

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Michigan authors

Herbert Raskin, MD, Detroit, "The problem of drug misuse and overmedication," page 383, *Federation Bulletin*, November, 1972.

Ronald L. Krome, MD, Yvan J. Silva, MD, Detroit, "The foreign medical graduate on the emergency care team," page 45, *Journal of the American College of Emergency Physicians*, November-December, 1972.

Cyrus Farrehi, MD, Flint, "Cardiovascular effects of carotid sinus nerve stimulation in resting man," page 121, *CHEST*, February, 1972.

F. A. Baughman, Jr., MD, and J. D. Mann, MD, Grand Rapids, "YY males in a private neurology practice," page 446, *Journal of the American Medical Association*, Oct. 23, 1972.

Paul Lowinger, MD, Detroit, "The politics of drugs," page 41, *Social Policy*, July-August, 1972.

Paul Lowinger, MD, and Karl Kish, MD, Detroit, "Do university programs in psychiatry serve the inner city?", page 276, *Journal of the National Medical Association*, July, 1971.

Paul Lowinger, MD, Detroit, "Radicals in psychiatry," page 24, *World Journal of Psychosynthesis*, March, 1972.

Paul Lowinger, MD, and Phillip L. Polakoff, MS, Detroit, "Do medical students 'turn on'?" page 185, *Comprehensive Psychiatry*, March, 1972.

S. J. Breiner, MD, Birmingham, "Psychological fundamentals of a sex education program, Part I," page 49, *Psychiatry Digest*, September-October, 1972.

The Cooperative Michigan Primary Care Preceptor Program:

Its development, characteristics and objectives

By Thomas J. Herrmann, MD
Robert R. Carpenter, MD
Ann Arbor
Robert M. Daugherty, MD, PhD
J. Thomas Parmeter, PhD
East Lansing
Alegro Godley, MD
Ruben Meyer, MD
Detroit

The goal is to produce more primary care physicians.

The method is to increase the number of graduates from Michigan's medical schools who consider and ultimately seek careers in this area.

The means is the new Cooperative Michigan Primary Care Preceptor Program, currently under development by the medical schools at the University of Michigan, Wayne State University and Michigan State University.

This program represents more than just three medical faculties joining forces. It represents a union of academic medicine and practitioners of medicine at the community level for the purpose of achieving their common goal of providing more and better primary care for the people of Michigan.

It is no secret that the number of medical school graduates going into primary care has been declining steadily over the past several decades.[1-5]

The problems of primary care are very real and undeniably important. It will be necessary to bring together all available resources if substantial progress toward a solution is to be made.

Thus, the University of Michigan Medical School, acting through its Medical Center Office of Community Medicine, is responsible for overall program coordination and the distribution of grant funds. Michigan also will develop and operate the system to match student applicants with available preceptors.

Wayne State University's School of Medicine, through its Department of Community and Family Medicine, has agreed to carry out the important job of selecting physician preceptors and coordinating the state-wide preceptor pool.

Michigan State University's College of Human Medicine will assume primary responsibility for preceptor training and program evaluation. MSU's Offices of Medical Education, Research and Development and of Health Services Education and Research will have major roles in carrying out these responsibilities.

It is expected that a pool of 250 community physicians around Michigan will be involved and trained initially to serve as physician-teachers of both observational and participating medical practice experiences for the students.

The new Michigan program got its start when the 92nd Congress passed the Comprehensive Health Manpower Training Act of 1971, establishing a Health Professions Special Project Grant to fund primary care preceptorship training programs for medical students.[6]

The medical schools of Michigan, agreeing that a substantive effort needs to be made in this area, chose to prepare and submit a joint grant application. The cooperative approach was selected because a state-wide network of primary care preceptors would provide the students of all three schools with a wider range and variety of training opportunities. The joint effort also took into account each school's particular areas of special interest and expertise, and the possibility of avoiding needless duplication and cost.

Doctor Herrmann is associate dean, assistant professor of surgery and assistant professor of postgraduate medicine at the University of Michigan Medical School, where Doctor Carpenter is director of Primary Care-Community Medicine and professor of internal medicine. Doctor Daugherty is director, Office of Interdepartmental Curriculum, professor in the departments of internal medicine and physiology and director of the hypertension clinic at Michigan State University's College of Human Medicine, where Doctor Parmeter is assistant to the dean for evaluation, Office of Medical Education, Research and Development. Doctor Godley is director of family medicine at Wayne State University School of Medicine, where Doctor Ruben Meyer is chairman of the Department of Community and Family Medicine.

Joint programming when feasible and practical has become a common goal of the state's medical schools. Beginning over two years ago, the deans and key administrative personnel from each of Michigan's four medical schools (that includes the MSU College of Osteopathic Medicine) have been meeting together regularly.

Representatives of the Michigan Academy of Family Physicians were fully involved in all of the planning committee's efforts and deliberations. The MSU College of Osteopathic Medicine provided knowledgeable faculty members as resource persons. Important and valuable background information was provided to the committee in the course of its work by the staff of the Michigan State Medical Society.

Thus, in August, the three medical schools were notified by HEW that a joint-five year award of nearly $2.2 million had been granted to support the development and operation of the state-wide preceptorship program to train students in the area of primary care.

These are the characteristics of the new Michigan program:

(1) A single, state-wide network of primary care preceptors will be developed to provide educational resource available to all Michigan medical students.

(2) Preceptors will be generalists, internists, and pediatricians with practice largely devoted to primary health care services.

(3) Students may choose from a broad range of geographic settings and a wide variety of practice patterns and reimbursement systems, from solo to prepaid groups.

(4) Individual preceptorships will vary from four weeks to 12 or more weeks.

(5) Formal instruction will be provided for the community physician-teachers, including program goals and objectives, educational techniques and skills. The program calls for preceptors in groups of 50 to complete two training sequences, one before any student assignment is made and a second midway through the physicians' first interaction with students.

(6) Two specific types of educational experiences for the students will be offered; one providing primarily observation for students in their first two years of medical school the second emphasizing participation and planned for advanced students with more prior patient care training.

(7) Students will submit a list of their preferred locations and will be matched randomly by computer with the preceptorship most closely meeting their choices.

(8) Counseling systems will be developed for students at each of the medical schools providing advice and information about careers in primary care. Practicing physicians will assist with this service.

An important factor in both preceptor selection and preceptor training will be the participation of practicing physicians in both of these processes.

The schools recognized early that practicing physicians should have a strong voice in the development, coordination and operation of the overall program. Representatives from the disciplines of family medicine, internal medicine and pediatrics have been included on the committee that will be created to formulate policy and oversee the program's operation.

The Michigan Academy of Family Physicians, MSMS, the American College of Physicians and the Michigan chapter, American Society of Pediatrics, will be asked to name representatives to a blue ribbon advisory committee which will meet on a biannual basis to review the program.

The schools believe that perhaps as many as 150 of their students will take part in the program during its first year and the number will increase to about 450 students by the third year. They believe also that freshmen and sophomores will be most likely to seek patient care experience during vacation periods and more advanced students will participate by taking medical school electives for academic credit during their third or fourth years.

To assist the students, a booklet will be prepared and made available annually listing all preceptorships available, including a biographical sketch of each preceptor and a description of the location and character of his practice. It also will identify the times each preceptorship will be available and what type of educational experience, observational, participatory or both, will be available at each location.

An important and unique aspect of this federal program is that it permits grant funds to be used to pay stipends and travel allowances for student trainees taking the preceptorships.

It is anticipated that many benefits will follow the new program.

The students will get a better understanding of medicine as it is really practiced in the community, an environment that is difficult, if not impossible, to duplicate at university centers.

The physician preceptors, who will not be compensated, will gain the satisfaction of helping young men and women toward their MD degrees. The physicians may possibly improve their skills,

Paralytic Shellfish poisoning

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Detroit

Although paralytic shellfish poisoning was recognized in Canada for many years,[1-3] little attention was given to this illness in the United States. However, on September 7, 1972, several New England states banned the collection of shellfish because of 33 reported cases.[7] It therefore was noteworthy that a Michigan resident was recently seen suffering from both paralytic poisoning and viral hepatitis from shellfish he ingested in eastern Canada.

On August 10, 1972, a 52-year-old zoology professor attended a beach party on Cape Tormentine, New Brunswick, Canada, where he dug, steamed briefly and ate a minimum of 24 clams. He was the only member of the party to eat clams, although fish caught in the same location that day were consumed by all. Twenty-four hours later, the patient awoke feeling nauseated, weak, with loss of coordination, numbness of the face and extremities, diplopia, and disorientation as to the passage of time. He collapsed in the bathroom without loss of consciousness and without tremor or convulsions. On August 13 he was treated for food poisoning with a mild cathartic. He was seen by a doctor on August 14, but by this time his symptomatology had cleared sufficiently for him to resume work. He was "treated for botulism" at that time. Weakness persisted for about one week.

No other member of the party suffered similar illness. In retrospect, the professor noted several dead fish on the beach, and also noted that a small stream into which a local village dumped raw sewage emptied into the sea about three miles from the clam bed.

On September 10, 1972, this patient was first seen at Ford Hospital complaining of jaundice, loss of appetite, weakness, malaise, darkening urine and lightening stools. He denied exposure to persons with hepatitis or exposure to needles. Physical exam revealed a jaundiced man with an enlarged, slightly tender liver extending ten centimeters below the right costal margin. Laboratory values during the hospital course were typical of viral hepatitis. Australia antigen test was negative. The patient was put into isolation, treated with bed rest and adequate diet, with

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PRECEPTOR PROGRAM/Continued

widen their fund of medical knowledge and renew their spirit of inquiry. Even if this assumption is only partly correct, a program that is designed to put 450 medical students in direct contact with 250 practicing physicians is bound to have a measurable impact on medicine as it is practiced in this state.

It is hoped also that through this program the value of the preceptorship model of instruction can be well demonstrated and documented.

Finally, but by no means least importantly, a program of the type described will serve to bring the medical schools of the State closer together and assist them in seeking even more substantive ways of working cooperatively in the future. This program, however, represents more than just three medical faculties joining forces. It represents a union of academic medicine and practitioners of medicine at the community level for the purpose of achieving their common goal of providing more and better primary care for the people of the State of Michigan. The problems of primary care are very real and undeniably important. It will be necessary to bring together all available resources if substantial progress toward a solution is to be made.

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resolution of symptoms, decrease in liver size, and return of laboratory values toward normal.

Paralytic shellfish poisoning has been recognized in eastern Canada since 1793, with recent epidemic outbreaks reported in the region of the Bay of Fundy in 1945 and again in 1957.[1,2] Symptomatology is due to ingestion of a toxin, Saxitoxin, elaborated by a protozoan dinoflagellate, *Gonyaulax tamarensis,* which inhabits the digestive tract and gills of clams in eastern Canada. These protozoa show a periodic increase in population, apparently dependent on an increase in water temperature, resulting in "red tides."[3,1,2] Saxitoxin is absorbed into the body of the clam without harm to the clam. The minimal lethal dose for man from oral ingestion is one to four milligrams, which can be contained in the body of one clam. It is not inactivated by cooking. Toxic clams are indistinguishable from non-toxic clams. The clinical features of intoxication are described as[1,2] the onset within thirty minutes of ingestion of tingling or burning of lips, gums, tongue, and face, spreading to other body parts, and later changing to numbness. Blood pressure falls. Ataxia, diplopia, and interference with speech and swallowing may progress to total paralysis. Consciousness is retained, usually with feelings of disorientation. Twitchings and convulsions are rare. Death, if it occurs, will ensue in less than twelve hours, and is usually due to respiratory failure. Survival beyond twelve hours signifies a good prognosis. The mechanism of Saxitoxin has been shown to be predominantly peripheral inhibition at the neuromuscular junction, cutaneous tactile endings and muscle spindles, with direct depression of muscle action potentials.[5] There appears to be no action directly on medullary or respiratory centers.[6] Thus, therapy should be aimed at maintaining respiration by artificial means rather than by central-acting drugs until the toxin can be cleared by the body.[7]

This case is somewhat atypical in that onset of symptoms apparently did not occur until 24 hours following ingestion. One explanation may be that alcohol ingestion may have masked the onset of numbness and tingling.

Infectious hepatitis transmitted via shellfish exposed to fecal contamination has been well documented.[5,8] Steaming of clams has been shown to be ineffective in inactivating virus, since the clams "gape" at temperatures below that required for inactivation. The appearance of typical findings of Australia antigen negative hepatitis in the absence of any exposure except to possibly contaminated clams four weeks prior to onset makes it very likely that this case represents viral hepatitis transmitted via the shellfish vector.

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Portal and peripheral blood insulin response to oral glucose in states of carbohydrate intolerance

By Ali Abbasi, M.D.
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Summary

Studies of several aspects of the response to oral glucose were undertaken in nine patients undergoing umbilical vein catheterization for suspected portal hypertension. Serum specimens were obtained in the fasting state, as well as five and 10 minutes after oral glucose and assayed for insulin-like activity (ILA) and immunoreactive insulin (IRI). Specimens came from the portal vein, a peripheral artery and a peripheral vein of each patient.

Mean ILA values exceeded mean IRI levels in the fasting state at all sites and continued to be greater than IRI values in the arterial and peripheral venous specimens soon after glucose loading. In the portal vein, however, IRI values exceeded peripheral IRI values at all times and after oral glucose exceeded ILA levels. The rise of portal IRI in the first five minutes after oral glucose was brisk and was not reflected in the periphery for at least another five minutes.

Introduction

Most of the studies dealing with insulin response to various stimuli in human subjects have involved measurements of peripheral venous concentrations. These provide inferential information of the actual biological characteristics of true pancreatic insulin. The dynamics of insulin and proinsulin release in diabetic subjects in response to intravenous glucose administration have been reported in the portal and peripheral venous systems.[1,2] Nevertheless, there is a paucity of information pertaining to studies of insulin in the portal system in the basal physiologic state.

This is a report of a study of the biological activity of insulin, before its subjection to the catabolic and metabolic effects by the liver, in which we obtained insulin concentrations in the portal and peripheral blood in nine carbohydrate intolerant patients in the intact unanesthetized state.

TABLE 1

CLINICAL DATA OF PATIENTS

No.	Patient	Sex	Age	Deviation from Ideal Body Weight	Pre-existing Disorders
1.	B.C.	F	37	+ 30%	Cirrhosis of the liver
2.	J.B.	M	50	- 10%	Cirrhosis of the liver; ethanolism
3.	E.K.	M	48	+ 10%	Diabetes mellitus; cirrhosis of the liver
4.	G.S.	M	38	- 10%	Cirrhosis of the liver
5.	R.C.	M	69	- 10%	Diabetes mellitus; ASHD; Cirrhosis of the liver
6.	F.P.	F	40	+ 20%	Cirrhosis of the liver; ethanolism
7.	J.H.	M	53	-8%	Duodenal ulcer; arterial hypertension
8.	L.E.	M	67	- 10%	Cirrhosis of the liver; emphysema; ethanolism
9.	E.L.	M	47	+ 25%	Cirrhosis of the liver

Materials and Methods

Nine patients were evaluated. Eight of them had cirrhosis of the liver and all of them had abnormal carbohydrate tolerance. (Table 1). Their ages ranged from 37 to 69 years. In all subjects, fasting serum glucose concentrations were less than 120 mg.% and the glucose tolerance test was within the diabetic range.[3] None of them was on antidiabetic treatment at the time of their admittance to the study. Three were obese (over 20% of their ideal body weight).

Portal vein catheterization was performed under local anesthesia by reopening the umbilical

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Doctor Abbasi is an instructor in medicine and Doctor Silva is associate professor of surgery at Wayne State University School of Medicine and Detroit General Hospital.

TABLE II

INSULIN CONCENTRATIONS EXPRESSED AS MICROUNITS/ML OF SERUM IN ARTERIAL, VENOUS, AND PORTAL VEIN BLOOD OF NINE DIABETIC PATIENTS

No	Patient	Portal Vein						Systemic Artery						Peripheral Vein					
		Fasting		5′ post-glucose		10′ post-glucose		Fasting		5′ post-glucose		10′ post-glucose		Fasting		5′ post-glucose		10′ post-glucose	
		IRI	ILA	IRI	ILA	IRI	ILA	IRI	ILA	IRI	ILA	IRI	ILA	IRI	ILA	IRI	ILA	IRI	ILA
1	BC	159	116	259	102	263	94	116	45	114	63	157	64	110	79	-	-	107	78
2	JB	127	50	284	65	296	35	60	12	80	28	53	17	58	25	60	-	60	16
3	EK	53	57	266	123	114	93	12	48	47	87	41	108	12	43	72	69	46	59
4	GS	14	44	93	119	152	140	11	70	-	-	45	39	8	56	24	108	27	46
5	RC	10	47	8	23	15	18	8	19	9	13	10	31	9	28	8	67	8	46
6	FP	47	121	74	315	41	368	13	175	23	199	20	255	15	177	22	243	17	188
7	JH	17	50	42	42	104	65	4	39	6	55	65	72	4	83	16	35	57	57
8	LE	11	53	147	109	123	128	5	42	25	99	25	68	5	60	-	-	25	64
9	EL	88	-	70	-	100	-	65	-	-	-	80	-	68	-	72	-	76	-
Median values		47	52	93	106	114	94	12	44	25	63	45	66	12	58	24	69	46	58

vein[4] and portal vein patency was maintained with heparinized normal saline by slow infusion for 24-48 hours. After an overnight fast, a Riley needle was placed in the femoral or brachial artery and an intravenous catheter inserted into an antecubital vein. Approximately 50 ml. of blood were drawn from the umbilico-portal catheter prior to obtaining a specimen designated the portal vein blood sample. It was withheld until the portal blood specimen was drawn and then reinjected within one to two minutes. This procedure minimized blood loss and provided specimens consisting solely of portal blood. Samples were obtained simultaneously from the portal vein, the femoral artery and the antecubital vein, and were drawn in the fasting state, and five and 10 minutes after the ingestion of 75 gms of glucose in the form of Glucola. All specimens were allowed to clot and three aliquots of the serum that was obtained were analyzed for glucose, immunoreactive insulin (IRI), and biological insulin (insulin-like activity).

Glucose concentrations were measured by a glucose oxidase method.[5] IRI was assayed by the double antibody technique of Morgan and Lazarow.[6] ILA was determined by a modification of the epididymal fat pad assay method[7] that utilizes the conversion of glucose I-C^{14} to C^{14}—labelled lipid as the index of ILA. To minimize the variations of insulin values determined in the bioassay,[8] all measurements of ILA were performed four to six times on the same blood sample and the median value of these determinations was used in the data.

Results

In all patients fasting IRI levels in the portal vein were higher than arterial or peripheral venous levels (Table 2), and the latter two values were equal. After glucose challenge the slight excess of arterial over venous IRI did not prove to be statistically significant (Table 3).

In the portal system, from a mean fasting IRI level of 58 ± 18.3 microunits/ml. there occurred a rather sharp rise in IRI concentrations to 138 ± 35.2 microunits/ml. five minutes after ingestion of oral glucose ($p < .05$). No further increase was observed 10 minutes post glucose loading. This marked elevation of portal insulin levels in response to glucose was associated with a sluggish change in peripheral insulin concentrations (Table 3).

As previously reported, the ILA values exceeded IRI levels in the fasting state[9] at all sites, and continued to be greater than IRI values in the arterial and peripheral venous specimens post glucose loading. Of interest in this regard were patients 1 and 2 who had IRI levels higher than their ILA levels at all three sites and at all times. (Table 2). In the portal vein, however, IRI values five and 10 minutes after oral glucose characteristically exceeded ILA levels with the exception of patients 5 and 6.

When insulin/glucose ratios are calculated as shown in Table 4, they demonstrate the greater responsiveness of the portal system to changes in glucose concentration compared to the peripheral systems.

TABLE III

INSULIN LEVELS OF THE NINE SUBJECTS STUDIED
(All values are means ± standard errors of the means)

Blood Source	Time	Glucose mg.%	ILA micro-units/ml	IRI micro-units/ml
Portal Vein	0'	91 ± 7.3	67 ± 11.3	58 ± 18.3
	5' post glucose	110 ± 8	112 ± 31.8	138 ± 35.2
	10' post glucose	129 ± 5.8	119 ± 39.2	136 ± 30.9
Systemic Artery	0	86 ± 6.4	56 ± 18.1	33 ± 13
	5' post glucose	96 ± 7.7	78 ± 19.9	43 ± 15.2
	10' post glucose	109 ± 5.1	82 ± 26.7	55 ± 14.7
Peripheral Vein	0'	87 ± 6.3	69 ± 17.2	32 ± 12.3
	5' post glucose	94 ± 7	104 ± 36.5	39 ± 10.5
	10 post glucose	101 ± 5.1	69 ± 18.1	47 ± 10.6

Discussion

Direct access to the portal system by umbilical vein catheterization provides an excellent opportunity to study some of the dynamics of human insulin response to oral glucose challenge. Attention has been directed towards assessing few characteristics of the early phase of insulin secretion.[2,10,11,12] Certain limitations must be born in mind when considering the data; none of our patients were well, none had normal carbohydrate tolerance, and all had suspected or proven liver disease. Furthermore, the study has not been extended to include healthy control subjects or established diabetics.

Although the fasting glucose levels of the portal vein and peripheral blood, were in close approximation, the IRI concentrations of the portal vein exceeded that of the periphery. The elevation of fasting insulin levels in the portal vein has been attributed to the autonomic nervous system function mediated via the vagus nerve.[13,14] After oral stimulation, however, there was marked rise of the portal IRI concentrations early after glucose challenge, whereas a sluggish peripheral response was observed. The marked difference between the portal and peripheral serum IRI concentrations is explained in the light of two factors; first, hepatic extraction of a considerable proportion of portal insulin as it passes through the hepatic bed,[15] and secondly the dilution of portal blood as it merges with the vena caval blood flow.

Evidence for a two pool insulin secretion system; a rapid-releasable pool and a time-dependent compartment has come from evaluation of the perfused rat pancreas[11] and the human pancreas;[12] and impairment of the early phase of insulin secretion in diabetes mellitus has been postulated as an early defect in the diabetic state.[10] An alternative explanation for the lag is a lack of feedback inhibition of insulin on insulin secretion.[16] Since studies on insulin response in human subjects have utilized peripheral venous insulin concentrations they provide inferential information on the dynamics of insulin secretion by the human pancreas. The portal vein insulin concentrations in response to intravenous glucose in 4 diabetic subjects studied recently[2] indicate an impaired early insulin release of the acute pool when compared with control nondiabetics. These individuals could have had pancreatic-type rather than essential genetic-type diabetes mellitus, because all had insulinopenia after intravenous glucose stimulation. In response to oral glucose, however, the portal IRI levels of six patients in our study rose sharply after challenge, three patients (subjects 5, 6 and 9) had

TABLE IV

IMMUNO-REACTIVE INSULIN/GLUCOSE RATIOS OF PORTAL, ARTERIAL, AND PERIPHERAL VENOUS SERA

Blood Source	Fasting	5 minutes after oral glucose	10 minutes after oral glucose
Systemic artery	0.35 ± 0.14	0.43 ± 0.15*	0.50 ± 0.14*
Peripheral vein	0.34 ± 0.14	0.40 ± 0.10**	0.45 ± 0.11**
Portal vein	0.61 ± 0.18	1.22 ± 0.36***	1.01 ± 0.22***

* $p < 0.10$ comparison to portal
** $p < 0.05$ comparison to portal
*** $p < 0.001$ comparison to fasting portal

sluggish portal insulin response and the possibility of pancreatic disease was raised. Furthermore the greater IRI/Glucose ratios of the portal vein after oral glucose do not corroborate the observation of an impaired early phase of insulin release.[2, 17, 18]

The interesting observation evoked by the discrepancies between IRI and ILA levels is provocative. ILA levels normaly exceed IRI concentrations[9] in the fasting state as well as after glucose loading, but this observation was inconsistent in our patients; subjects 5 and 6 had higher ILA values as expected; however subjects 3, 4, 7 and 8 had equal or higher IRI concentrations in the portal vein after glucose challenge but lower values in the fasting state. Subjects 1 and 2 disclosed greater IRI values in all sites and in both fasting and post glucose loading states.

Why some patients should manifest lower biological than immunological assayable insulin is a matter of speculation. The first item to consider is elevated levels of circulating forms of insulin with low biological activity such as proinsulin that reduce ILA values and can still be detected by immunoassay. Secondly a pancreatic insulin precursor may be converted during its journey through the liver into a more active form.[19, 20, 21] Therefore the measured biological insulin activity exceeds immunoassayable insulin values only in the peripheral blood (subjects 3, 4, 7 and 8). Thirdly ILA could originate in the liver[22] and reduced levels of ILA in liver disease or diabetes might ensue. Fourthly the presence of an undefined glucose-responsive insulin antagonist could explain some of these findings. It is conceivable that we are dealing with an inconsistent group of patients who appear to have different forms of diabetes mellitus, the syndrome of heterogeneous etiologies.

In general, our data disclosed higher mean levels of biologically assayable than immunoassayable insulin in the peripheral blood both in the fasting state and after oral glucose stimulation, whereas the opposite was observed in the portal venous blood post-oral glucose. Therefore these observations are consistent with the notion of "insulin" with a reduced biological activity appearing in the portal system, at least in the early phase after oral glucose challenge. Whether proinsulin is released abnormally in high concentrations in diabetics, as a result of a defect in the conversion of proinsulin to true insulin[19, 20, 23-29] is also an interesting consideration.

Acknowledgment

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George Dean, MD, at head of table, chaired the recent program for the MSMS-sponsored "Workshop for Medical Reporters" about the need for more family doctors in Michigan. Held at WSU Scott Hall in Detroit, The WSU Medical School provided the luncheon. Thirty-one reporters, free lance writers, communications specialists for related groups and workshop speakers participated. Doctor Dean, Southfield, is chairman of the PR Committee of the Michigan Academy of Family Physicians.

During a break in the medical news workshop, Robert Vitu, MD, left, president of MAFP, was interviewed for a CKLW radio program by newsman, Keith Radford.

Many WSU medical students would like to spend summer SAMA-MECO experiences in the Detroit area, Mark Campbell, foreground, WSU sophomore, told the medical writers. MSMS arranged for Mark to spend last summer at the Dearborn General Hospital as one of 92 students placed. Across the table, at the right, is John Bruder, president, WSU SAMA chapter.

MSMS tells news media about family physicians

Evaluation of fluocinonide cream

By Ralph J. Coskey, MD
Henry G. Bryan, MD
Detroit

The purpose of this report is to summarize our experience treating 84 patients with the new topical corticosteroid, 0.05% fluocinonide, the 21 acetate of fluocinolone acetonide.[1] **(Fig. 1)** (Drawing of molecule). Fluocinonide is formulated in a specifically designed base which has the properties of both a cream and an ointment. The base, FAPG,® contains mainly stearyl alcohol and propylene glycol. It is designed to provide optimum conditions for the release of the steroids and its penetration into the skin.[2]

Several investigators have found 0.05% fluocinonide cream to be more effective than other topical steroids in psoriasis, atopic dermatitis, contact dermatitis, eczematous dermatitis, seborrheic dermatitis and lichen planus. Thus Mendelson and Bessler[3] found it to be superior to 0.5% hydrocortisone cream in the treatment of psoriasis and lichen planus and superior to 0.5% hydrocortisone and 0.1% betamethasone valerate in the treatment of atopic dermatitis.

Binder and McCleary[1] in a double blind study found fluocinonide 0.05% cream statistically superior to 0.1% betamethasone cream in 36 patients with psoriasis, eczematous dermatitis, seborrheic dermatitis and atopic dermatitis.

Rosenberg,[4] in a double blind study comparing 0.05% fluocinonide cream with 0.1% betamethasone valerate cream in 24 patients, found fluocinonide to produce superior results in the majority of instances.

Roth and McCleary[5] also evaluated fluocinonide by comparing it with 0.5% hydrocortisone cream in 60 patients with psoriasis and atopic dermatitis and found it to be superior.

In addition to the clinical studies we have just described, investigators have shown by the McKenzie and Stoughton vasoconstrictor test or modifications of it, that fluocinonide is a very potent topical corticosteroid. These tests measure the amount of blanching produced by a topical corticosteroid as there is a strong correlation between the amount of blanching produced by these agents and their clinical effectiveness.[2,6,7,8]

Method

Eighty-four patients with different steroid responsive dermatoses were treated with 0.05% fluocinonide in FAPG* base. This product was applied unoccluded four times daily for 14 days. The patients were seen after seven and 14 days. Their response to therapy was graded 2+ for an excellent response, 1+ for moderate improvement, 0 for no change, and -1 for worse.

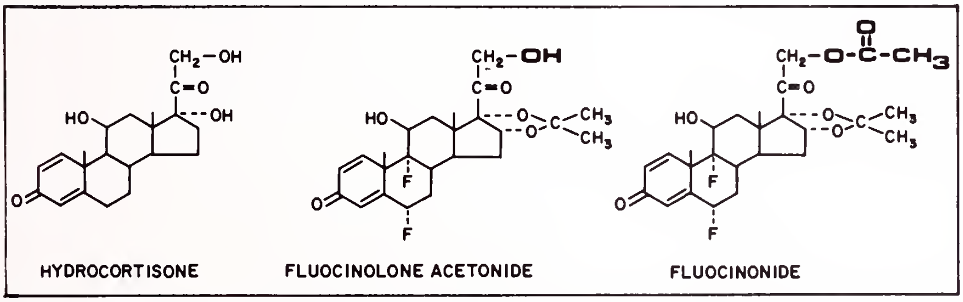
Results

The results of therapy can be seen in Table 1. Fluocinonide proved to be an excellent drug for the treatment of the majority of patients with psoriasis, seborrheic dermatitis, contact dermatitis, nummular eczema and lichen simplex chronicus. It was also helpful for atopic dermatitis, chronic eczematous dermatitis and dermatoses such as granuloma annulare, pruritus ani, pickers nodules, discoid lupus erythematosus, perioral dermatitis and toxic dermatitis. It was not helpful for the majority of patients with acne vulgaris.

We found that patients with generalized psoriasis did not respond as well to therapy as did those with psoriasis localized to a few areas. The best responses were seen when lesions on the face and intertrignous were treated.

Although the scope of this study was to evaluate fluocinonide cream for 14 days, when patients with psoriasis were followed for months, it was found that most often they had to continue using this agent or their lesions would revert back to their former status.

Patients with other chronic dermatoses such as seborrheic dermatitis, nummular eczema,



Fluocinonide differs from fluocinolone acetonide by the substitution of an acetate for the hydroxyl radical at the 21 position.

Doctor Coskey is adjunct assistant professor and Doctor Bryan is adjunct instructor in the Department of Dermatology at Wayne State University School of Medicine.

Table I

Response to Therapy (84 patients)

Diagnosis	Excellent (2 +)	Moderate (1 +)	No change (0)	Worse (-1)	Total
Psoriasis	18	9	1	1	29
Seborrheic Dermatitis	12				12
Contact Dermatitis	5	3			8
Nummular Eczema	4	3			7
Lichen Simplex Chronicus	5				5
Chronic Eczematous Dermatitis	4	4			8
Acne Vulgaris		3	3		6
Granuloma Annular	1	1			2
Pruritus Ani	1				1
Lichen Planus		1	1		2
Pickers Nodules (face)		1			1
Discoid Lupus Erythematosus	1				1
Perioral Dermatitus		1			1
Toxic Erythema		1			1
Total					84

chronic eczematous dermatitis and lichen simplex chronicus responded very well to therapy but also had to continue using fluocinonide cream after this study was completed to prevent a relapse.

Summary

An open trial of fluocinonide 0.05% in FAPG[8] cream on 84 patients with different steroid sensitive dermatoses was conducted. The diagnoses included psoriasis, seborrheic dermatitis, contact dermatitis, atopic dermatitis, nummular eczema, chronic eczematous dermatitis, lichen simplex chronicus, acne vulgaris, lichen planus, granuloma annular, pruritus ani, pickers nodules, discoid lupus erythematosus, perioral dermatitis and toxic erythema.

In the majority of cases fluocinonide cream produced excellent results after unoccluded application four times daily for 14 days. No unfavorable side effects were noted and no patients dropped out of the study. The findings suggest that fluocinonide is an excellent addition to the topical corticosteroid agents that are available for clinical use at the present time.

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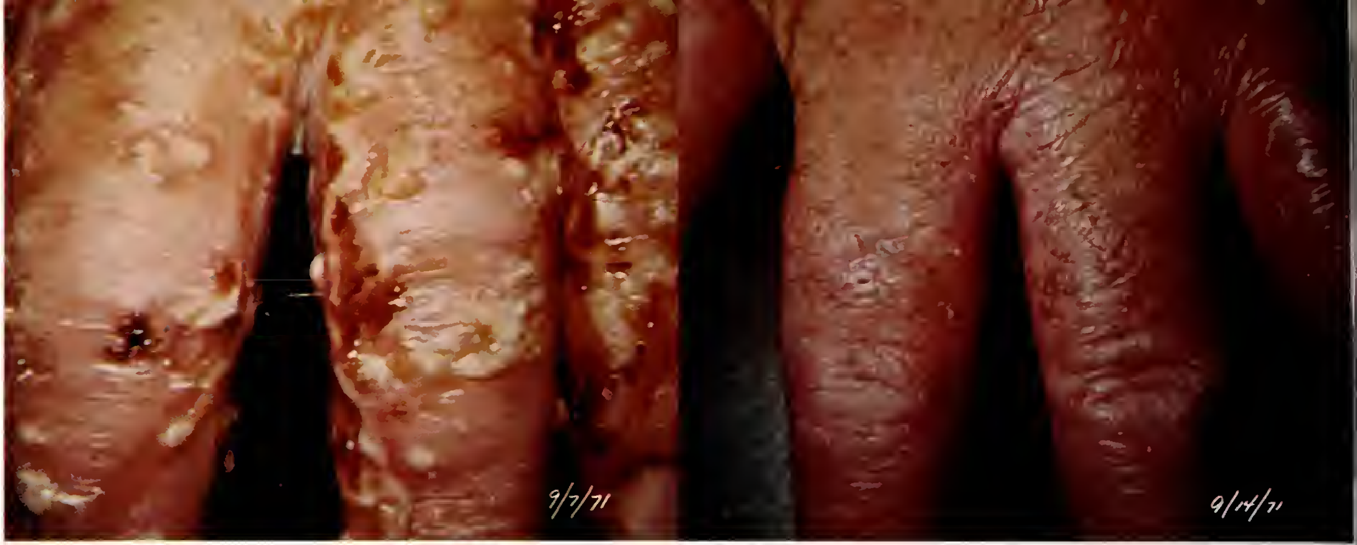
dia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.



MINOCIN® made the difference in just eight days.*

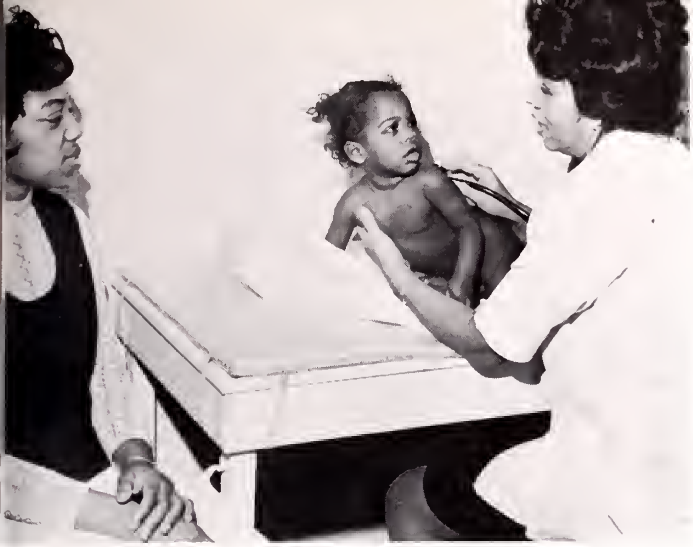
Clinical Data:
Patient: 47-year-old male.
Diagnosis: Severe pyoderma, left hand.
Culture: *Staphylococcus aureus, coagulase* positive and sensitive to MINOCIN.
Temperature: 102° F
Therapy: MINOCIN Minocycline HCl Capsules, 100 mg: 200 mg *stat,* 100 mg every 12 hours. Medication began 9/7/71. By fourth day, temperature was normal and pustular lesions considerably improved. Last dose taken 9/14/71.
Concomitant therapy: None.†

Semisynthetic
MINOCIN®
MINOCYCLINE HCl
Capsules, 100 mg: 2 *stat,* 1 q 12 h.

Minocycline is a tetracycline with activity against a wide range of gram-negative and gram-positive organisms.
Contraindications: Hypersensitivity to any tetracycline.
Warnings: The use of tetracyclines during tooth development (last half of pregnancy, infancy and childhood to the age of 8 years) may cause permanent discoloration of the teeth (yellow-gray-brown). This is more common during long-term use but has been observed following repeated short-term courses. Enamel hypoplasia has also been reported. Tetracyclines, therefore, should not be used in this age group unless other drugs are not likely to be effective or are contraindicated. In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, use lower doses, and, in prolonged therapy, determine serum levels. Photosensitivity manifested by an exaggerated sunburn reaction has been observed in some individuals taking tetracyclines. Advise patients apt to be exposed to direct sunlight or ultraviolet light that such reaction can occur, and discontinue treatment at first evidence of skin erythema. Studies to date indicate that photosensitivity does not occur with MINOCIN Minocycline HCl. In patients with significantly impaired renal function, the antianabolic action of tetracycline may cause an increase in BUN, leading to azotemia, hyperphosphatemia, and acidosis. Pregnancy: In animal studies, tetracyclines cross the placenta, are found in fetal tissues, and can have toxic effects on the developing fetus (often related to retardation of skeletal development). Embryotoxicity has been noted in animals treated early in pregnancy. Safety of use during human pregnancy has not been established. *Newborns, infants and children:* All tetracyclines form a stable calcium complex in any bone-forming tissue. Prematures, given oral doses of 25 mg./kg. every 6 hours, demonstrated a decrease in fibula growth rate, reversible when drug was discontinued. Tetracyclines are present in the milk of lactating women who are taking a drug of this class. Safe use has not been established in children under 13.
Precautions: Use may result in overgrowth of nonsusceptible organisms, including fungi. If superinfection occurs, institute appropriate therapy. In venereal diseases when coexistent syphilis is suspected, darkfield examination should be done before treatment is started and blood serology repeated monthly for at least four months. Patients on anticoagulant therapy may require downward adjustment of such dosage. Test for organ system dysfunction (e.g., renal, hepatic and hemopoietic) in long-term use. Treat all Group A beta hemolytic streptococcal infections for at least 10 days. Avoid giving tetracycline in conjunction with penicillin.
Adverse Reactions: (Common to all tetracyclines, including MINOCIN) GI: (with both oral and parenteral use): anorexia, nausea, light-headedness, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in anogenital region. *Skin:* maculopapular and erythematous rashes. Exfoliative dermatitis (uncommon). Photosensitivity is discussed above ("Warnings"). *Renal toxicity:* rise in BUN, dose-related (see "Warnings"). *Hypersensitivity reactions:* urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus. When given in high doses, tetracyclines may produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur. In young infants, bulging fontanels have been reported following full therapeutic dosage, disappearing rapidly when drug was discontinued. *Blood:* hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
NOTE: *Concomitant therapy:* Antacids containing aluminum, calcium, or magnesium impair absorption; do not give to patients taking oral minocycline. Studies to date indicate that MINOCIN is not notably influenced by foods and dairy products.

***Indicated in infections due to susceptible organisms. Culture and sensitivity testing recommended. Tetracyclines are not the drugs of choice in the treatment of any staphylococcal infection.**
†Case Report, Clinical Investigation Department, Lederle Laboratories.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 10965 436-2



Mother and child are the focal points of services provided by the Detroit Maternal and Infant Care Project through its seven satellite clinics located in areas of Detroit where the maternal and infant mortality rates are highest. Here, a reluctant baby girl undergoes her monthly checkup at the Crittenton Hospital Clinic with Rosario Itchon, MD.

Infant mortality in Michigan:

Situation improving, but much to be done

By Judith Marr
Managing Editor

"Tell them for me," she said, though she did not know her interviewer's audience, "that this is a wonderful place."

She was small and slim, about 26 years old, and had an air of confidence. She was making her last visit to the Crittenton Hospital Clinic of the Detroit Maternal and Infant Care Project.

She was bringing her second baby, an energetic one-year-old, for the last check-up in the clinic's program of well-baby care. Then she was off to pick up her supply of contraceptive pills, for, with her, she said, it was "two and out."

"I came here with my first baby because I had to come here," said the young mother, "I couldn't afford to go anywhere else." And she had returned, with her second, because "they take care of you here from the time you get pregnant. And they take care of the baby until he's one year old.

"Everything is taken care of for you right here; you don't have to worry about odds and ends."

This young mother is one of a total of 3,500 women in the city of Detroit who, each year since 1964, have received free from the DMIC "a quality of obstetrical care that not only compares with the best of private care but among whose clients the perinatal mortality rate is even better than that of private patients in the same hospital."

That is according to Acting Director C. J. Berger, MD, Lansing, chief, Division of Maternal Health, Michigan Department of Public Health, who commutes to Detroit twice a week to administer the project. He has held the acting directorship from January, 1970 to May, 1971, and again since September. Between May, 1971 and September, Beryl B. Spruce, MD, Ann Arbor, served as acting director.

The Detroit Maternal and Infant Care Project was initiated in 1964 to improve the health care of mothers and infants in the Detroit inner city. It has aimed at improving, the perinatal, infant and maternal death rates of those women and babies, who because of their lack of education, substandard living conditions, poor nutrition and lack of medical attention present a high risk to their successful pregnancy and childbirth.

It is those same perinatal and infant mortality rates, which are higher in the U.S. than in several other countries, that are being held, publicly and privately, as an indictment of U.S. medicine. (Perinatal deaths, described as those occurring after the first 20 weeks of gestation and up to one week after delivery, are included among infant deaths which are all those occurring up to one year of age.)

Recently, at the MDPAC annual luncheon Oct. 2 in Detroit, Sec. of State Richard Austin described his difficulty in answering a student's question: "Why is our country, the richest in the world, number 14 among industrial countries in the infant death rate?"

Mr Austin quoted statistics that show the infant death rate is four times as high in the poorest section of Detroit as it is in the affluent areas. He continued by saying that "the crisis of medical care in the United States . . . reflects the crisis of inequality which permeates every area of our society."

(Continued on page 55)

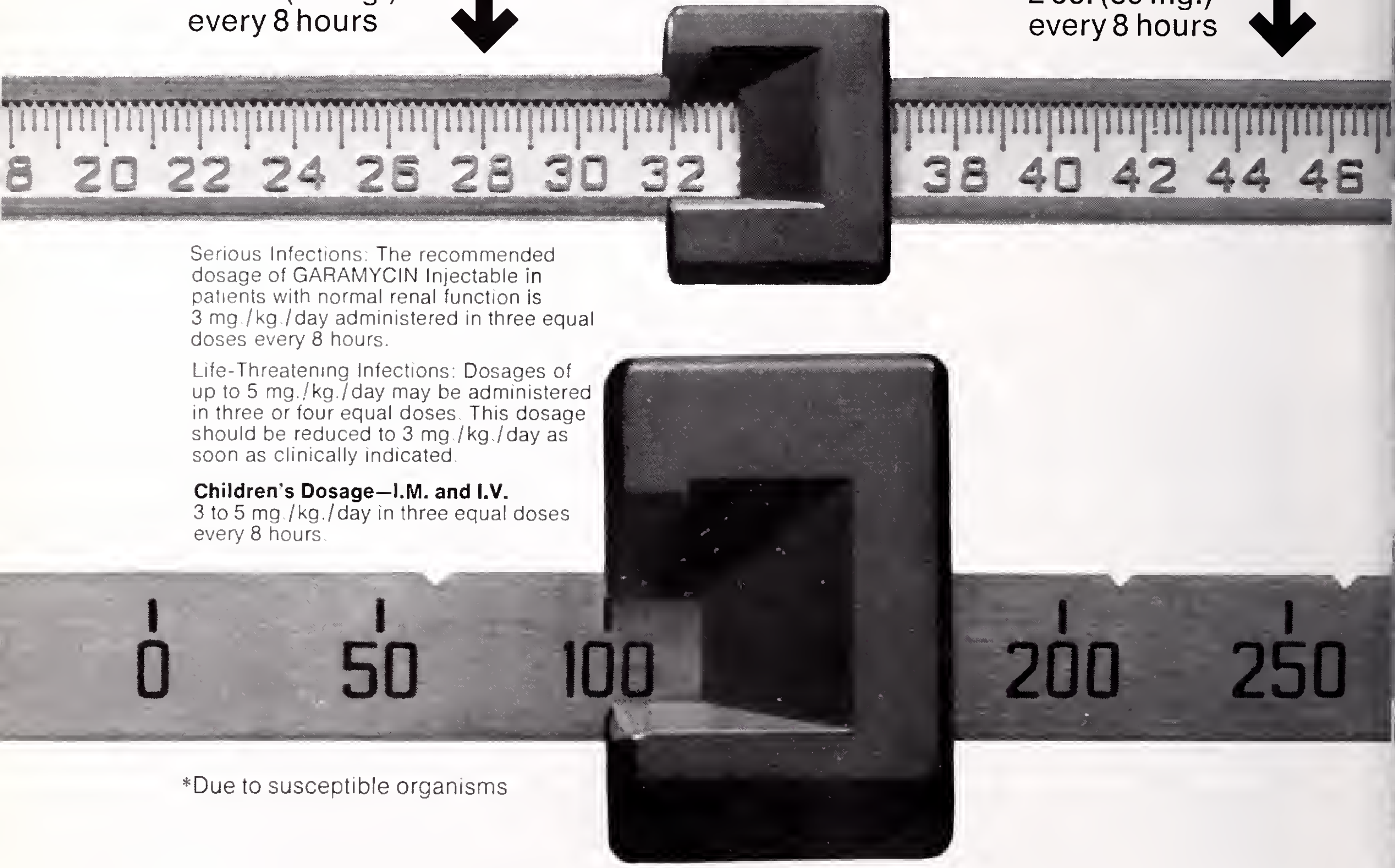
In serious gram-negative infections*

Simplified dosage guidelines

Usual adult dosage - - I.M. and I.V. - - in patients with normal renal function

132 lbs. or less
1.5 cc. (60 mg.)
every 8 hours

Over 132 lbs.
2 cc. (80 mg.)
every 8 hours



Serious Infections: The recommended dosage of GARAMYCIN Injectable in patients with normal renal function is 3 mg./kg./day administered in three equal doses every 8 hours.

Life-Threatening Infections: Dosages of up to 5 mg./kg./day may be administered in three or four equal doses. This dosage should be reduced to 3 mg./kg./day as soon as clinically indicated.

Children's Dosage—I.M. and I.V.
3 to 5 mg./kg./day in three equal doses every 8 hours.

*Due to susceptible organisms

WARNING
Patients treated with GARAMYCIN Injectable should be under close clinical observation because of the potential toxicity associated with the use of this drug.

Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment.

Monitoring of renal and eighth nerve function is recommended during therapy of patients with known impairment of renal function. This testing is also recommended in patients with normal renal function at onset of therapy who develop evidence of nitrogen retention (increasing BUN, NPN, creatinine or oliguria). Evidence of otot icity requires dosage adjustments or continuance of the drug.

In event of overdose or toxic reactic peritoneal dialysis or hemodialysis will in removal of gentamicin from the blo

Serum concentrations should be moni ed when feasible and prolonged concen tions above 12 mcg./ml. should be avoid

Concurrent use of other neurotoxic ai or nephrotoxic drugs, particularly strep

Schering

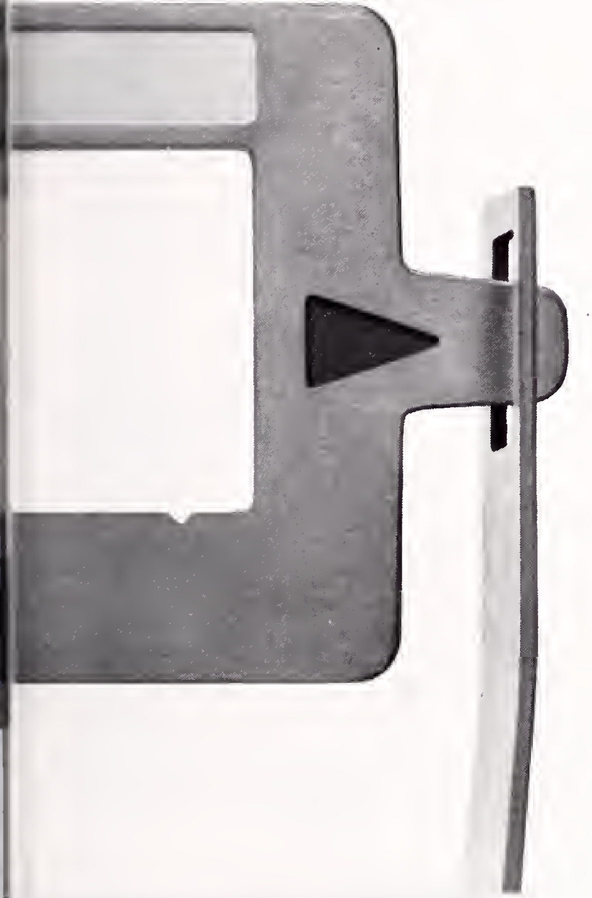
Garamycin®

gentamicin sulfate injectable

I.M./I.V.

40 mg. per cc.

Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin



Duration of therapy—I.M. and I.V.

The usual duration of treatment is 7 to 10 days. In difficult and complicated infections, a longer course of therapy may be necessary.

Instructions for I.V. use

Dilution—A single dose is diluted in 100 or 200 cc. of sterile normal saline or in a sterile solution of dextrose 5% in water; in infants and children, the volume of diluent should be less. The concentration of gentamicin in solution should not exceed 1 mg./cc. (0.1%).

Infusion time—The solution is infused over a period of 1 to 2 hours.

Premixing—GARAMYCIN Injectable should not be physically premixed with other drugs but should be administered separately in accordance with the recommended route of administration and dosage schedule.

In adults with impaired renal function

The single dose of GARAMYCIN Injectable given by patient weight remains the same; however, the interval between doses must be extended.

This interval may be approximated by multiplying the serum creatinine by eight as follows:

Serum creatinine × 8 = frequency of administration
(mg./100 ml.) (in hours)

This dosage schedule is not intended as a rigid recommendation, but is provided as a guide to dosage when the measurement of gentamicin serum levels is not feasible.

See Clinical Considerations section which follows...

neomycin, kanamycin, cephaloridine, :in, polymyxin B, and polymyxin E in), should be avoided. concurrent use of gentamicin with po- ıretics should be avoided, since certain cs by themselves may cause ototoxic- addition, when administered intrave- , diuretics may cause a rise in gentami- um level and potentiate neurotoxicity. E IN PREGNANCY Safety for use ŋnancy has not been established.

Schering

Garamycin® Injectable
brand of gentamicin sulfate U.S.P., injection, 40 mg./cc.
Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin
For Parenteral Administration

WARNING: Patients treated with GARAMYCIN Injectable should be under close clinical observation because of the potential toxicity associated with the use of this drug.

Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment.

Monitoring of renal and eighth nerve function is recommended during therapy of patients with known impairment of renal function. This testing is also recommended in patients with normal renal function at onset of therapy who develop evidence of nitrogen retention (increasing BUN, NPN, creatinine or oliguria). Evidence of ototoxicity requires dosage adjustments or discontinuance of the drug.

In event of overdose or toxic reactions, peritoneal dialysis or hemodialysis will aid in removal of gentamicin from the blood.

Serum concentrations should be monitored when feasible and prolonged concentrations above 12 mcg./ml. should be avoided.

Concurrent use of other neurotoxic and/or nephrotoxic drugs, particularly streptomycin, neomycin, kanamycin, cephaloridine, viomycin, polymyxin B, and polymyxin E (colistin), should be avoided.

The concurrent use of gentamicin with potent diuretics should be avoided, since certain diuretics by themselves may cause toxicity. In addition, when administered intravenously, diuretics may cause a rise in gentamicin serum level and potentiate neurotoxicity.

USAGE IN PREGNANCY Safety for use in pregnancy has not been established.

INDICATIONS GARAMYCIN Injectable is indicated, with due regard for relative toxicity of antibiotics, in the treatment of serious infections caused by susceptible strains of the following microorganisms:

Pseudomonas aeruginosa, Proteus species (indole-positive and indole-negative), **Escherichia coli** and **Klebsiella-Enterobacter-Serratia** species.

Clinical studies have shown GARAMYCIN Injectable to be effective in septicemia and serious infections of the central nervous system (meningitis), urinary tract, respiratory tract, gastrointestinal tract, skin and soft tissue (including burns).

Bacteriologic tests to determine the causative organisms and their susceptibility to gentamicin should be performed.

Bacterial resistance to gentamicin develops slowly in stepwise fashion; there have been no one-step mutations to high resistance.

In suspected or documented gram-negative sepsis, GARAMYCIN may be considered as initial therapy. The decision to continue therapy with this drug should be based on the results of susceptibility tests, the severity of the infection, and the important additional concepts contained in the Warning Box. In the neonate with suspected sepsis or staphylococcal pneumonia, a penicillin type drug is usually indicated as concomitant antimicrobial therapy.

GARAMYCIN Injectable has been shown to be effective in serious staphylococcal infections. It may be considered in those infections when penicillins or other less potentially toxic drugs are contraindicated and bacterial susceptibility testing and clinical judgment indicate its use.

CONTRAINDICATIONS A history of hypersensitivity to gentamicin is a contraindication to its use.

WARNINGS See Warning Box.

PRECAUTIONS Neuromuscular blockade and respiratory paralysis have been reported in the cat receiving high doses (40 mg./kg.) of gentamicin. The possibility of these phenomena occurring in man should be considered if gentamicin is administered to patients receiving neuromuscular blocking agents such as succinylcholine and tubocurarine.

Treatment with gentamicin may result in overgrowth of nonsusceptible organisms. If this occurs, appropriate therapy is indicated.

ADVERSE REACTIONS

Nephrotoxicity: Adverse renal effects, as demonstrated by rising BUN, NPN, serum creatinine and oliguria, have been reported. They occur more frequently in patients with a history of renal impairment treated with larger than recommended dosage.

Neurotoxicity: Adverse effects on both vestibular and auditory branches of the eighth nerve have been reported in patients on high dosage and/or prolonged therapy. Symptoms include dizziness, vertigo, tinnitus, roaring in the ears and hearing loss.

Numbness, skin tingling, muscle twitching, and convulsions have also been reported.

Note: The risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.

Other reported adverse reactions, possibly related to gentamicin, include increased serum transaminase (SGOT, SGPT), increased serum bilirubin, transient hepatomegaly, decreased serum calcium; splenomegaly, anemia, increased and decreased reticulocyte counts, granulocytopenia, thrombocytopenia, purpura; fever, rash, itching, urticaria, generalized burning, joint pain, laryngeal edema; nausea, vomiting, headache, increased salivation, lethargy and decreased appetite, weight loss, pulmonary fibrosis, hypotension and hypertension.

DOSAGE AND ADMINISTRATION GARAMYCIN Injectable may be given intramuscularly or intravenously.

For Intramuscular Administration:

PATIENTS WITH NORMAL RENAL FUNCTION*

Adults: The recommended dosage for GARAMYCIN Injectable for patients with serious infections and normal renal function is 3 mg./kg./day, administered in three equal doses every 8 hours.

For patients weighing over 60 kg. (132 lb.), the usual dosage is 80 mg. (2 cc.) three times daily. For patients weighing 60 kg. (132 lb.) or less, the usual dose is 60 mg. (1.5 cc.) three times daily.

In patients with life-threatening infections, dosages up to 5 mg./kg./day may be administered in three or four equal doses. This dosage should be reduced to 3 mg./kg./day as soon as clinically indicated.

*In children and infants, the newborn, and patients with impaired renal function, dosage must be adjusted in accordance with instructions set forth in the Package Insert.

For Intravenous Administration:

The intravenous administration of GARAMYCIN Injectable is recommended in those circumstances when the intramuscular route is not feasible (e.g., patients in shock, with hematologic disorders, with severe burns, or with reduced muscle mass).

For intravenous administration, in adults, a single dose of GARAMYCIN Injectable may be diluted in 100 or 200 cc. of sterile normal saline or in a sterile solution of dextrose 5% in water; in infants and children, the volume of diluent should be less. The concentration of gentamicin in solution, in both instances should normally not exceed 1 mg./cc. (0.1%). The solution is infused over a period of 1 to 2 hours.

The recommended dose for intravenous administration is identical to that recommended for intramuscular use.

GARAMYCIN Injectable should not be physically pre-mixed with other drugs, but should be administered separately in accordance with the recommended route of administration and dosage schedule.

HOW SUPPLIED GARAMYCIN Injectable, 40 mg. per cc., 2 cc. multiple-dose vials for parenteral administration.

Also available, GARAMYCIN Pediatric Injectable, 10 mg. per cc., 2 cc. multiple-dose vials for parenteral administration. APRIL, 1972

AHFS Category 8:12.28

For more complete prescribing details, consult Package Insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033. SLR-192

Garamycin®
gentamicin sulfate
injectable
I.M./I.V.

40 mg. per cc.

Each cc. contains gentamicin
sulfate equivalent to 40 mg. gentamicin

The DMIC, begun in 1964, was the first considered effort to improve maternity and infant care in Michigan ghetto areas. It now offers complete medical care for expectant mothers and their infants, as well as in-depth medical and public health counseling, instruction in food preparation and buying, expectant parents classes, family planning counseling, sewing lessons, day care for mothers with appointments at clinics and most recently, complete dental care. The hygienist is Deborah Rosser.

INFANT MORTALITY/Continued

Recent figures show the U.S. infant death rate is greater than Japan's, Sweden's and The Netherlands. Critics have pointed to these figures and America's doctors with accusing fingers; while others less critical also have raised thoughtful questions.

Many others have debated using figures such as those comparing the U.S. infant mortality rate with rates in The Netherlands and Sweden, pointing out that those are countries much smaller than the U.S. and with homogeneous populations.

Author Harry Schwartz, member of the New York *Times* Editorial board, observes in his new book, "The Case for American Medicine," that "international comparisons can be misleading if made without consideration for the huge differences between individual countries with regard to their populations and life patterns.

"What the data does suggest," he continues, "is that it is highly homogeneous nations—like Japan, Sweden and the Netherlands—that now are registering the best records in saving the lives of infants. The argument that it is somehow only the deficiencies of the private practice of medicine that explains this country's ranking in the infant mortality sweepstakes can seem persuasive only to the statistically unsophisticated."

Doctor Berger, notes that Sweden provides programs that subsidize the working mother, encouraging her to quit working at her sixth or seventh month of pregnancy.

That is in contrast to the U.S., where, he says, "there is no incentive for the mother to quit working. Rather, she is forced to continue working to keep body and soul together almost until the labor pains start."

Those conditions precipitate premature labor, says Doctor Berger, and it is his conclusion that the greater proportion of premature labors and deliveries in the U.S. is what makes our infant death rate higher.

"Sweden is no magical case," he says, "the doctors and nurses there are not better. They just don't deliver the premature babies we do."

The DMIC and Prescad, its affiliate project which serves infants and children of the City of Detroit, through their care of mother and infant, have dropped the premature birth rate among project infants from 16.5% in 1967 to 11.6% in 1970, according to the latest available figures.

At the same time, the prematurity rate around the state was dropping from 79.28 premature births per 1,000 in 1969 to 78 premature births per 1,000 or 7.8 per cent, in 1971.

According to a Nov. 10 release from the Michigan Department of Public Health, the mortality rate of infants in the projects dropped from 47.4 per cent in 1968 to 30.1 per cent in 1970. And from a high-risk group of close to 2,800 mothers in the inner city of Detroit, only two deaths occurred.

Other indications of success in the program are the increasing numbers of mothers who keep their return appointments—up from 60 per cent to 90 per cent since the initiation of the program, according to Doctor Berger. In addition, most mothers now are making their first visits to DMIC clinics in their first trimester, rather than their last, as was the case in the first years of the projects' existence.

Nationwide, the situation is improving, also, as evidenced by a recent report of the National Center for Health Statistics.

The NCHS announced this fall that the infant mortality rate in the U.S. dropped to 18.6 per 1,000 live births for the first half of 1972—the lowest rate ever recorded—and 4.5 per cent below the 19.6 recorded for the similar period of 1971.

Statewide, the infant death rate in 1971 was placed by the Center for Health Statistics of the state health department at 19.5 per 1,000 births, while the perinatal death rate was computed at 25.2 per 1,000 births.

Recent advances in care for indigent Detroit mothers and babies include family planning services and dental care at the seven DMIC satellite clinics.

Secondly, the "long-standing history of fragmented, ill-coordinated, poorly supervised prenatal and postpartum care given by the city obstetrical clinic has been corrected," according to Doctor Berger, "so that each patient now knows long in advance her precise delivery site and is cared for by a full-time obstetrician-gynecologist. The actual day-to-day clinic services have been significantly upgraded."

Thirdly, he says, there is assurance that Wayne County Commissioners will approve payment for inpatient care when no third party payor can be found, thus encouraging many hospitals now reluctant to provide a program for indigent women to add their input to medical resources in the Detroit inner-city areas.

In addition, a reclarification of rules and guidelines by the Department of Social Services will now permit the use of Title XIX Medicaid funds to reimburse hospitals with obstetrical clinics for care rendered indigent patients in outpatient department clinics.

"These hospitals probably will open their doors for the first time to a significant number of medically indigent patients and they will be encouraged to add staff beyond the normal basic type for prenatal and postpartum services," says Doctor Berger.

Finally, the MDPH is expanding the battlefield.

"A review of the impact of the special comprehensive health projects for mothers and children in the Detroit area provides compelling evidence for a need to implement similar programs in other areas of the state—especially those having high maternal and infant mortaility and morbidity statistics," says a Nov. 10 release from the Department.

This need has been recognized by the legislature which has appropriated money to the Bureau of Maternal and Child Health for 1972-73 to expand medical care programs like the DMIC to the medically indigent in selected out-state areas

The DMIC staff consists of the acting director, an administrative assistant, chief nutritionist, chief public health nurse, chief home economist, chief medical social worker, and public health educator. Both mother and infant at each satellite clinic have full staffs of similar personnel available as well as medical and social workers, physicians and nurses. Each mother has her own physician who follows the entire course of her pregnancy. At each appointment, she is seen by all clinic staff members whose care she needs, including, above, Crittenton Visiting Nurse Mrs. Forest (Ethel) Owens, RN.

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that are in particular need of such care.

Initally, programs are contemplated in Grand Rapids, Muskegon and Berrien County. The appropriation is approximately $2 million and includes both state and federal funds.

"High risk mothers and children need not only medical services, but nursing, nutrition and socioeconomic assistance and health education," says Maurice S. Reizen, MD, director, MDPH. "A team working together as in the Detroit projects can make the difference. It takes money and professional involvement to carry out such programs, but the evidence for their value is available."

Therefore, as we have shown, there *is* a problem. The U.S. perinatal mortality rate *is* higher than that of other countries'; it is especially high among non-white populations of the U.S. And the overall Michigan rate exceeds the national figures.

However, much has been done to lower infant mortality rates in this country and particularly in Michigan. And the efforts are working, bringing death rates of babies to all-time lows.

"The Michigan State Medical Society has, through its committee on Maternal and Perinatal Health, from the date of inception of this project in Detroit, continued to lend much needed and much appreciated professional guidance and counselling to insure the development of even more effective levels of quality care for these patients," says Doctor Berger.

Yet "it is difficult to separate the actions of organized groups such as the medical society from the dedicated services of individual physicians working in the actual clinic sites rendering direct care to such patients," he continues.

Doctor Berger has high praise for other individual physicians "who have contributed much success to this major improvement in maternal and infant care in Detroit," including the Chief of the Bureau of Maternal and Child Health, R. G. Rice, MD; the immediate past chairman of the MSMS Committee on Maternal and Perinatal Health, James Harryman, MD, Muskegon; the current committee chairman, Richard C. Mellis, MD, Kalamazoo; Chairman of the Department of Obstetrics-Gynecology at Wayne State University, Tommy N. Evans, MD; the Director of Medical Services at Project Prescad, Irving Posner, MD, and the recently-resigned Director of the DMIC, Doctor Spruce.

According to Hermann A. Ziel, Jr., MD, chief, Bureau of Health Facilities, MDPH, "The best example of positive productive action by physicians to meet the demands and needs of society in Michigan is the exemplary work on the MSMS Maternal Health Committee."

According to Jack R. Postle, MD, Petoskey, current chairman of the Perinatal Mortality and Morbidity Subcommittee, the MSMS Maternal Health Committee recognizes that lowering maternal and perinatal death rates requires efforts in the fields of education and socioeconomics, as well as in medical areas, and has given its guidance and support to a wide variety of programs.

In 1968, following the National Center for Health Statistics' publication of infant mortality figures which showed the U.S. lagging, the MSMS committee, along with several other groups, carried out an investigation.

Studying all aspects of care as it was then available in Detroit, the committee concluded, among other things, that in order to make good obstetrical care available in the inner city of Detroit, the Medicaid program would have to undertake financing of prenatal care, as well as delivery care.

"The committee brought its priorities to the attention of the State Bureau of Social Services and the necessary changes were made," says Doctor Postle.

"This kind of help, coupled with the excellent work of the DMIC and the WSU Department of Obstetrics are hopefully at this time whittling away at the hard core of difficult but preventable perinatal deaths in Detroit."

What Michigan's doctors can do:

Individual physicians practicing medicine in Michigan can do much to lower the infant death rate of the state. Here are some specific suggestions:

Jack R. Postle, MD, Petoskey, chairman, Perinatal Mortality and Morbidity Subcommittee, MSMS Committee on Maternal and Perinatal Health:

Each hospital should critically review its own perinatal deaths, and care given, with the thought of improving that care in the future. Each obstetrical department should review its procedures in the light of the tremendous advances in perinatology to see if the staff and the nurses are availing themselves of the latest information and techniques in the care of patients. (A consultant to aid in this review easily could be made available to any hospital upon request to the MSMS Committee.)

"Finally, and most important, each physician must keep alert for the early warning signs that identify the high risk mother or her high risk offspring and see to it that all necessary modern medical facilities can be appropriately mobilized in her behalf."

William W. Jack, MD, Grand Rapids, former chairman, MSMS Committee on Maternal and Perinatal Health:

The medical profession should support all constructive community efforts to improve living conditions among the needy.

The medical profession should emphasize the association between the mother's nutritional status and her performance during pregnancy and encourage further investigations into nutritional influences which affect infant mortality and morbidity.

The medical profession should stimulate the reduction of infant mortality and morbidity through the development of immunological techniques and the advancement of genetic counseling programs.

Charles J. Berger, MD, director DMIC, and his staff, to help them in their work:

"If a Detroit-area physician ascertains that his pregnant patient is going to need extra care, would benefit from nutritional and social counseling, and most importantly, is not going to be able to pay him for the care the physician provides, the doctor should refer her as early as possible to the DMIC."

Detroit physicians should know more about the feelings, the living conditions, the life situations of indigent persons. "Doctors need to be more involved in the total lives of the people they serve," Doctor Berger comments. "There are many other needs after their health."

Doctor Ziel, of the Bureau of Health Statistics—

"There is great opportunity for physicians to shape the development of more comprehensive, coordinated health policy which is essential to governmental and non-governmental programming.

"Mr. Austin's plea to physicians 'to flex your political muscle' is indeed worth heeding particularly if this is done in a positive way to improve the physical, mental and social health of the individuals at professional services."

Maurice S. Reizen, MD, director, MDPH,

"The Michigan Department of Public Health needs the support of the Michigan State Medical Society and all the individual physicians in Michigan to support expansion of programs similar to the DMIC in other areas of the state with unacceptable rates of maternal and infant mortality and prematurity."

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Michigan medi/cene

Jan. 10—MSMS workshop for component society legislative chairmen, 2 p.m., MSMS headquarters, contact: Mrs. Sherry Hall, MSMS headquarters

Jan. 20-21—Midwinter seminar, American Association of Medical Assistants, State of Michigan Branch, Hayes Hotel, Jackson, contact: Margaret Broadwell, president, 406 Professional Plaza, 3800 Woodward Ave., Detroit, 48201

Jan 24—The Council, MSMS headquarters, contact: Warren F. Tryloff, MSMS director

Jan. 30—Board meeting, Woman's Auxiliary to MSMS, MSMS headquarters, contact: Mrs. Fleming Barbour, 2015 Lincoln Drive, Flint, 48503

Jan. 31—Council of Specialty Societies, 2 p.m., MSMS headquarters, contact: Glenn E. Moore, MD, president, 323 W. Second, Flint, 48503

Feb. 2-3—National symposium on the needs and goals of black medical students, Rackham Auditorium, University of Michigan, contact: John A. Gronvall, MD, dean, U-M Medical School, Ann Arbor, 48104

Feb. 6-10—American Group Psychotherapy Association, Hilton Hotel, Detroit, contact: Margaret Keefe, administrative secretary, 1865 Broadway, New York 10023

Feb. 7-9—Western Michigan Nuclear Medicine Conference, Holiday Inn, Petoskey, sponsored by Hackley Hospital, Muskegon, and Central chapter of the Society of Nuclear Medicine, contact: James C. Carlson, MS, Hackley Hospital, 1700 Clinton St., Muskegon

Feb. 11-15—Symposium, "How does change occur in psychotherapy?" Shanty Creek Lodge, Bellaire, contact: Reuven Bar-Levav, MD, 823 Fisher Building, Detroit 48202

Feb. 24—February seminar, "Human diseases of trace metal metabolism," sponsored by Michigan Society of Pathologists, Henry Ford Hospital, Auditorium, contact: Jacob E. Briski, MD, Pathology Department, Saint John Hospital, 22101 Moross Road, Detroit, 48236

Feb. 26-March 2—Clinical gastroenterology postgraduate course sponsored by the American College of Physicians, Towsley Center, University of Michigan Medical Center, Ann Arbor, contact: H. M. Pollard, MD, 2012 Vinewood Blvd., Ann Arbor 48104

Feb. 28—Council of Specialty Societies, 2 p.m. MSMS headquarters, contact: Glenn E. Moore, MD, president, 323 W. Second, Flint, 48503

March 11—Michigan Academy of Family Physicians, noon, MSMS headquarters, contact: Mrs. Rita Feldkamp, secretary, 933 Wing St., Plymouth, 48170

March 16-17—25th anniversary symposium, "Epilepsy '73," sponsored by Epilepsy Center of Michigan, Wayne County Medical Society headquarters, contact: Miss Cheek, Epilepsy Center of Michigan, 10 Peterboro, Detroit, 48201

March 18—Board meeting, American Association of Medical Assistants, State of Michigan Branch, MSMS headquarters, contact: Margaret Broadwell, 406 Professional Plaza, 3800 Woodward Ave., Detroit, 48201

March 20—Annual Legislative Day, Woman's Auxiliary to MSMS, Olds Plaza Hotel, Lansing, contact: Mrs. R. J. Westerhoff, 2458 Maplewood, SE, Grand Rapids, 49506

March 21—The Council, MSMS headquarters, contact: Warren Tryloff, director

March 21-22—Annual Michigan Conference on Maternal and Perinatal Health, Olds Plaza Hotel, Lansing, contact: Helen Schulte, MSMS headquarters

March 28—Council of Specialty Societies, 2 p.m., MSMS headquarters, contact: Glenn E. Moore, MD, president, 323 W. Second, Flint, 48503

April 26-29—Annual state convention, AAMA, Michigan branch, Dearborn Inn, Dearborn, contact: Margaret Broadwell, 406 Professional Plaza, 3800 Woodward Ave., Detroit 48201

May 4-5—Sixth Annual Cancer Symposium, "Management of Advanced Breast Carcinoma," sponsored by Wayne State University School of Medicine and American Cancer Society—Michigan Division, and Michigan Cancer Foundation, Wayne County Medical Society headquarters, $25 fee, contact: Mrs. Dorothy Bewley, Symposium Registrar, 4160 John R Street, Detroit, 48201

May 9—May seminar, Michigan Society of Pathologists, Scott Hall, Wayne State University, 1:30 p.m., contact: Jacob E. Briski, MD, St. John Hospital, Detroit, 48236.

May 10-11—Annual Gull Lake meeting, MSMS Committee on Maternal and Perinatal Health, Kellogg Biological Station, Gull Lake, contact: Helen Schulte, MSMS headquarters

May 10-11—Sixteenth annual Clinic Days, Children's Hospital of Michigan, at new hospital in Detroit Medical Center, contact: Edward W. Green, MD, Children's Hospital, 3901 Beaubien Blvd., Detroit, 48201

May 13-15—Second annual spring meeting, MSMS House of Delegates, Boyne Mountain lodge, Boyne Falls, contact: Richard Campau, MSMS headquarters

May 15-16—Spring conference, Woman's Auxiliary to MSMS, Hidden Valley Lodge, Gaylord, contact: Mrs. Fleming Barbour, 2015 Lincoln Drive, Flint, 48503

May 23—Council of Specialty Societies, 2 p.m., MSMS Headquarters, contact: Glenn E. Moore, MD, president, 323 W. Second, Flint, 48503

June 1-2—Annual Keyport Trauma Day, Hidden Valley Lodge, Gaylord, contact: B. E. Henig, MD, 308 Michigan Ave., Grayling, 49738

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Any of the commonly used T_4 thyroid function tests (P.B.I., T_4 By Column, Murphy-Pattee, Free Thyroxine) are useful in monitoring patients on T_4 because they *all* measure T_4. Patients on SYNTHROID are thereby easy to monitor because their results will fall within predictable, elevated test ranges. Of course, clinical assessment is the best criterion of the thyroid status of the drug-treated patient.

TEST	HYPOTHYROID	SYNTHROID THERAPEUTIC NORMAL
P.B.I.	Less than 4 mcg %	6-10 mcg %
T_4 By Column	Less than 3 mcg %	7-9 mcg %
T_3 (Resin)	Less than 25%	27-35%
T_3 (Red Cell)	Less than 11%	11.5-18%
Free Thyroxine	Less than 0.7 nanograms %	0.7-2.5 nanograms %
Murphy-Pattee	Less than 2.9 mcg %	4-11 mcg %

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The conversion has been linically demonstrated during the dministration of T_4 to athyrotic atients. Their thyroid status is ormalized on SYNTHROID alone, et the presence of T_3 in these atients has been clearly shown.

WHY DOES SYNTHROID COST LESS THAN SYNTHETIC DRUGS CONTAINING T_3?

Very simple. T_3 costs more to make synthetically than does T_4. So it is economically necessary for a synthetic thyroid medication containing T_3 to cost more than one containing T_4 alone. Synthetic combinations cost patients nearly 50% more than SYNTHROID[3] because the T_3 costs more to start with; also there is the additional expense of formulating a tablet containing two active ingredients.

1. Latiolais, C. J., and Berry, C. C.: Misuse of Prescription Medications by Outpatients, *Drug Intelligence & Clin. Pharm.* 3:270-7, 1969.
2. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T4) to Triiodothyronine (T3) in Athyreotic Human Subjects, *J. Clin. Invest.* 49:855-64, 1970.
3. American Druggist BLUEBOOK, March, 1971.

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Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose, preferably after breakfast. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) for Injection may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

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Physicians can help find drug diverters

Michigan physicians are being asked to join forces with the state government to uncover persons who are diverting legal drugs into illegal channels. Unless a direct cooperative effort is brought to bear on the problem, experts believe drug availability for abuse will remain at a high level.

With the assistance of the federal government, the state has initiated an all-out war on the diversion of legal drugs. Specifically, the Michigan Board of Pharmacy of the Department of Licensing and Regulation has been charged with locating those persons who are channelling drugs into illegal use. Currently there are 25,000 registered to handle and process all controlled substances.

A Diversion Investigation Unit (DIU) has been formed by the Department of Licensing and Regulation, the Department of State Police, Federal Bureau of Narcotics and Dangerous Drugs, the Governor's Office of Drug Abuse and the Office of Criminal Justice Programs.

The DIU will trace the source of legitimate controlled substances found in the illicit market and is interested primarily in dealing with the root causes of diversion and the person or persons responsible.

DIU offices are located at 15000 W. Eight Mile Road, Oak Park, 48237, and at 1106 S. Washington Ave., Lansing, 48926.

Governor Milliken creates new health office

A state Office of Health and Medical Affairs is now at work within the Executive Office serving as a focal point for Gov. William G. Milliken's health policy advice. Gov. Milliken created the new office by executive order Nov. 22. Donald C. Smith, MD, the Governor's Principal Advisor on Health and Medical Affairs, is director.

The new office, according to Gov. Milliken, will work cooperatively with major health-related state departments and private organizations. It will assume the principal responsibility for planning, monitoring and coordinating the utilization of health resources under the control or influence of state government.

The former Office of Comprehensive Health Planning and the Health Impact Project will be consolidated into the new agency.

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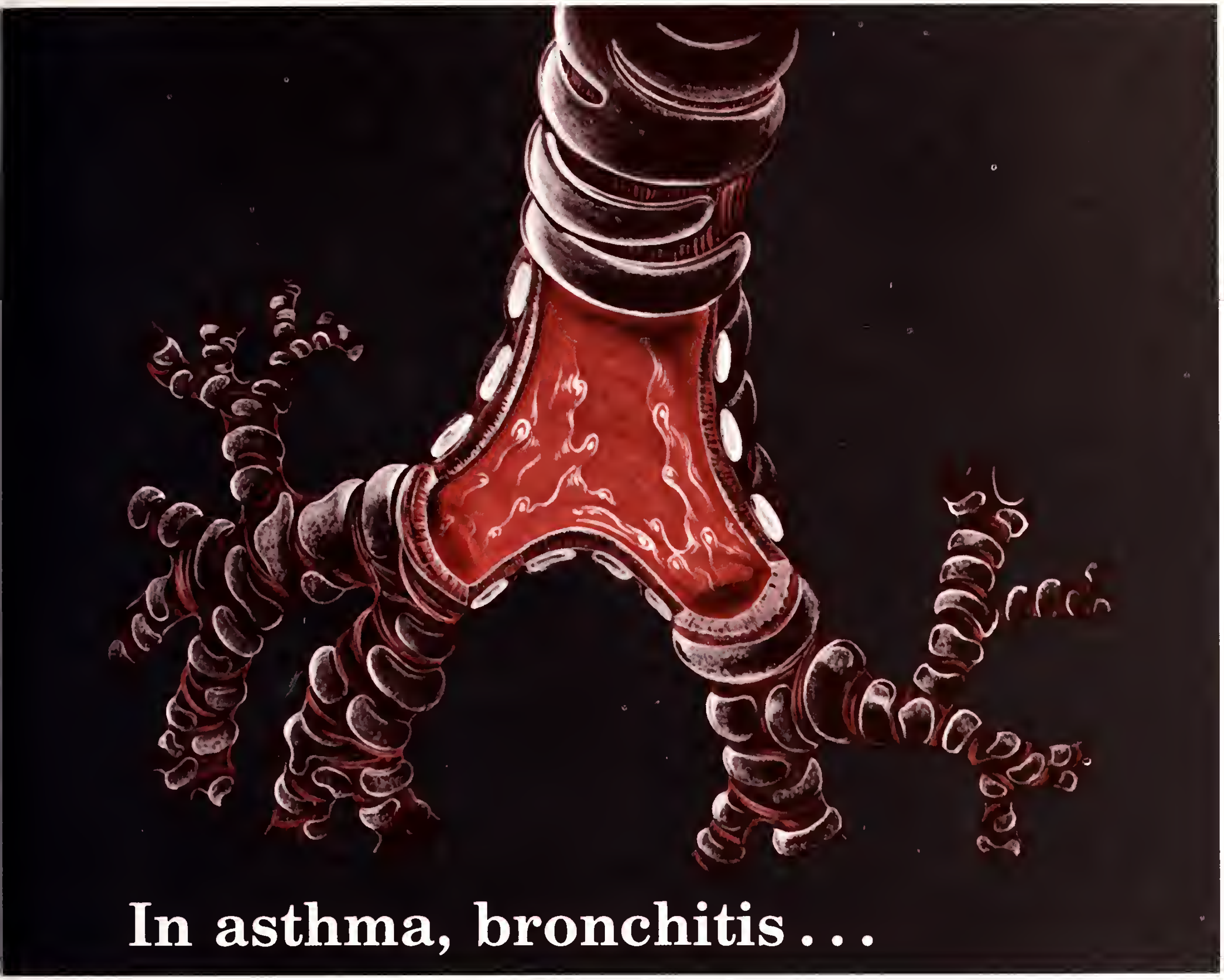

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"Many physicians use iodides intravenously when they suspect that the main reason for airway obstruction is sticky mucus but oral iodides are more likely to exert an expectorant action."[1]

"For the viscid sputum, potassium iodide (. . . preferable as enteric coated tablets) may be best."[2]

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please see next page for prescribing information—

Promote Productive Cough-

"The productive cough serves the necessary purpose of removing excess mucus from the bronchial tree."[3]

". . . there is clear evidence that the loosening of the bronchial mucus blanket must begin from within the underlying mucus glands where it is anchored and not from the surface. Complications of iodides are too occasional to avoid the use of this valuable medication."[3]

Rx Information:

INDICATIONS: The primary indication for Iodo-Niacin is in any clinical condition where iodide therapy is desired. All of the usual indications for the iodides apply to Iodo-Niacin and include:

RESPIRATORY DISEASE: The use of Iodo-Niacin is indicated whenever an expectorant action is desired to increase the flow of bronchial secretion and thin out tenacious mucus as seen in bronchial asthma, and other chronic pulmonary disease. Iodo-Niacin has also proven of value in sinusitis, bronchitis, bronchiectasis, and other chronic and acute respiratory diseases where the expectorant action of iodide is desired.

THYROID DISEASE: Iodo-Niacin is indicated in any thyroid disorder due to iodine deficiency, such as endemic goiter or hypoplastic goiter, and where hypothyroidism is secondary to iodine deficiency. Iodo-Niacin will suppress mild hyperthyroidism completely, and partially suppress more severe hyperthyroid states. Iodo-Niacin is also of value in suppressing the symptoms of hyperthyroidism and decreasing the size and vascularity of the thyroid gland prior to thyroidectomy.

ARTERIOSCLEROSIS: Iodides have been reported as relieving some of the symptoms associated with arteriosclerosis. The mechanism of action is unknown, but the effects are documented.

OPHTHALMOLOGY: Iodo-Niacin has been reported to be of value in retinal and vitreous hemorrhages. The mechanism of action is unknown, but absorption of the hemorrhagic areas has been observed following use of this drug. It is also reported to be of value in reducing or removing vitreous floaters.

SIDE EFFECTS: Serious adverse side effects from the use of Iodo-Niacin are rare. Mild symptoms of iodism such as metallic taste, skin rash, mucous membrane ulceration, salivary gland swelling, and gastric distress have occurred occasionally. These generally subside promptly when the drug is discontinued. Pulmonary tuberculosis is considered a contraindication to the use of iodides by some authorities, and the drug should be used with caution in such cases. Rare cases of goiter with hypothyroidism have been reported in adults who had taken iodides over a prolonged period of time, and in newborn infants whose mothers had taken iodides for prolonged periods. The signs and symptoms regressed spontaneously after iodides were discontinued. The causal relationship and exact mechanism of action of iodides in this phenomenon are unknown. Appropriate precautions should be followed in pregnancy and in individuals receiving Iodo-Niacin for prolonged periods.

DOSAGE: The oral dose for adults is two tablets after meals taken with a glass of water. For children over eight years, one tablet after meals with water. The dosage should be individualized according to the needs of the patient on long-term therapy.

HOW SUPPLIED: Cole's Iodo-Niacin tablets are available in bottles of 100, 500 and 1,000. Slosol coated pink. NDC 55-6458.

IODO-NIACIN®

Each SLOSOL tablet contains potassium iodide 135 mg. and niacinamide hydroiodide 25 mg. Sig. *ii* tabs. t.i.d. p.c.

References: 1. Itkin, I. H., Am. Fam. Phys. 4:83, 1971. 2. Feinberg, S. M., Consultant Sept., 1971, pg. 32. 3. Bookman, R., Ann. Allerg. 29:367, 1971.

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MSMS conference message:

Physicians must lead the way to improving our environment

By Herbert A. Auer, Manager
MSMS Dept. of Communications

"Every doctor should be a medical detective for environmental health."

That challenge was issued by Maurice Reizen, MD, director of Michigan Health Department, at the MSMS-sponsored third annual Great Lakes Conference on Environmental Quality Control in Detroit.

The working conference drew invited representatives of the Ontario Medical Society and the state societies of Pennsylvania, Ohio, Illinois and Minnesota to Detroit for two days to join MSMS leaders.

"Physicians must determine new ways to provide leadership to solve new environmental issues," declared Edward Klopp, MD, Battle Creek, conference chairman. The challenge was paraphrased also by Louis Zako, MD, Westland, chairman of the hosting MSMS Committee on Public and Environmental Health, who told the delegates, "doctors can use their scientific training and daily medical practice in unbiased efforts to improve the environment."

"TO BE MOST EFFECTIVE in pollution control efforts, we need a new positive approach," observed F. T. H. Porter, MD, assistant secretary of the Ontario Medical Association. Doctor Porter said we must strive to develop "a desire on the part of all citizens for something better." He contended that, "there has never been a control laid down, a law passed, which could not be circumvented by someone determined to do so."

"We must develop a positive attitude towards healthy living and emphasize the inherent value of people, not things," Doctor Porter said.

Physicians must lead the way "to develop a uniform, national and international approach to pollution in the Great Lakes area which will leave no haven for the polluter," declared Doctor Porter.

In his discussion about water pollution, Doctor Porter warned "our medical profession cannot stand by and let new and different pollutants be discharged into our waterways."

Doctors must lead studies to determine levels of the many pollutants in the air, said J. F. Tomashefski, MD, of the Cleveland Clinic. Doctor Tomashefski recommended that every medical school should have a Division of Environmental Health.

"It is unrealistic to think we can obtain perfect water, air and land. We must establish proper criteria for control of limited pollution from our necessary industrial economy," he said.

THERE ARE MANY REASONS to be deeply concerned about soil pollution and one of them is in "respect to the quality and safety of our water supply," Doctor Reizen, MD, said. Doctor Reizen identified many soil pollution problems, such as land filling, municipal and industrial waste disposal, septic tanks, contaminated water supplies, chemical contamination of ground waters, open dumps, etc.

In citing problems, Doctor Reizen urged "more

Physicians, legislators and representatives of medical and health agencies from Ontario, Ohio, Pennsylvania, Illinois, and Minnesota joined Michigan participants at the Detroit Metropolitan Hilton Inn for the third annual MSMS "Conference on the Physician and Environmental Quality Control."

Pennsylvania participants in the recent Great Lakes Conference were Joseph H. Schwerha, MD, seated right, Chairman of the Pennsylvania Medical Society Committee on Environmental Health, and Kenneth B. Jones, seated left, PMS committee staffer. They are discussing conference recommendations with three members of MSMS sponsoring committee, all standing left to right, John L. Isbister, MD, Lansing, John H. Kitchel, MD, Grand Haven, and Louis R. Zako, MD, Westland, chairman.

Discussing medical aspects of pollution at the MSMS conference are, left to right, Edward Psizczek, MD, Chicago, representative of the Illinois State Medical Society; State Rep. Raymond Smit, Ann Arbor; and Richard Rasmussen, MD, Grand Rapids, member of Michigan Commission on Air Pollution.

Two Ontario pollution experts share ideas at the MSMS-sponsored Great Lakes conference with Edward J. Klopp, MD, Battle Creek, conference chairman for MSMS. Ontario speakers were F. T. H. Porter, MD, left, assistant secretary of Ontario Medical Association, and E. Mastromatteo, MD, an Ontario health official from Toronto, right.

research on disposal methods for tons of solids that were formerly discharged into the atmosphere or to the waters."

"The dimensions of land pollution are staggering. Solid waste disposal differs," he said, "from other man-made land contaminants and provides a more complicated problem."

"We must find and utilize new techniques that will minimize the need for land disposal of solid waste," Doctor Reizen declared.

Physicians were warned by John S. Chapman, MD, Dallas, chairman of the AMA Council on Environmental and Public Health, to confine their pollution remarks to those with medical import. Whenever a doctor oversteps this advice, he is speaking only as a citizen.

Doctor Chapman proposed that doctors should help establish regulations for pollution levels where risks may be injurious. "Doctors can help attest to the need to determine the proper levels of risk," he said.

The AMA committee chairman urged doctors to testify before legislative bodies in order to provide necessary medical leadership in pollution efforts.

TWO MICHIGAN LEGISLATORS spoke at the conference and asked for greater advice and assistance from the medical profession. Rep. Thomas Anderson and Rep. Ray Smit described the difficulties of legislative effort in the pollution areas because many people are opposed to eruptions of employment, profits, routines, and habits. The legislators especially cited the need for more medical research about noise pollution and air pollution.

Too many environmental control decisions are being made, they said, by attorneys with too little input from doctors.

The legislators recognized that doctors must be given more notice when invited to appear before legislative hearings.

"Citizens may not have the right to indiscriminately pollute," commented Richard A. Rasmussen, MD, Grand Rapids, a member of the State Air Pollution Control Commission. He described the work of the Commission and his special concerns as a physician member. He voiced his strong personal objections to cigaret smoking, smiling as he said, "While all burning may not be harmful, all cigaret burning is."

The efforts of the Michigan Student Environmental Confederation were explained by Walter Pomeroy, Lansing, MSEC Coordinator. The state health department has helped finance several MSEC summer projects.

Viewpoints:

The malpractice problem

Perry W. Greene, Jr. MD
Grand Rapids

The incidence of malpractice claims and suits in Michigan has been increasing in recent years beyond reality. One company estimates it is processing between 300 and 400 claims in the state at the present time. Approximately 10% of these claims will be filed as legal suits, and of those that are "found in favor of the plaintiff," about 50% will be reversed in appellate courts. Thus the chances of the courts ruling against a physician for medical malpractice and/or negligence are very slim according to available statistics.

But the biggest problem lies in all the other cases, and it is to the prevention of these other cases that attention must be directed. These involve unsatisfactory results, breech of contract, legal negligence, lack of consent, etc., and not medical malpractice in the true sense of the word. No one wants to see medical malpractice go unpunished, but no one wants the constant threat of malpractice claims where no malpractice exists.

A few years ago a "malpractice package" was introduced into the State Legislature and unfortunately died in the House Judiciary Committee. This package included bills which:

1. Would allow insurance companies to pay claims without assuming liability.
2. Would allow hospital records to be subpoenaed without starting a malpractice claim.
3. Would require that the statute of limitations be tried as a separate suit if needed.
4. Would require posting a $500 forfeiture bond before filing a claim.

A "package" of this nature would brighten the malpractice situation in Michigan considerably, but would be no cure-all. It would be helpful if the lawyers would abandon the contingent fee system, but this will never be. If the physician-patient relationship were ideal, there would be no claims for unsatisfactory results, breech of contract, abandonment—but perfection does not exist, and people are claims-conscious at this time.

The HEW has ascertained that the cost of malpractice insurance is becoming a factor in medical expense, and that the fear of malpractice claims has created "defensive medicine" which causes an even greater and more artificial increase in the cost of medical care. A federal study committee was created when it was found that only 15% of malpractice premiums go to pay for plaintiff settlements. Not too long ago the highest price malpractice policy sold by a leading insurance company was $105 per year, now it is over $2,500 and some physicians, through no fault of their own, cannot buy malpractice insurance in Michigan.

In my opinion we must seek help from the legislators to pass laws such as mentioned above to make it more difficult to file "nuisance claims." We must seek help from the Bar Association to help set up definitive mediation panels to prevent filing for unfounded claims (i.e., where no medical malpractice exists), and we must consider a system of self insurance to assume that all physicians can purchase malpractice insurance at reasonable rates.

(Between the time this is written and the time it is published, the rates for malpractice insurance in Michigan have risen 20%.)

Earl J. Cline
Legal Counsel
Genesee County Medical Society

The fast-expanding problem of medical malpractice litigation is a problem that can be corrected, in my opinion, only by legislation, either on a national or state level.

Since the advent of no-fault automobile insurance in October of 1972, this writer already has been defending more malpractice cases brought by attorneys who would never have started a malpractice case before, and who formerly referred those cases to four or five firms of lawyers in the state who specialize in plaintiff's malpractice work. I can visualize the trend continuing and that there will be more and more spurious malpractice cases started simply because the average practicing attorney in the State of Michigan cannot distinguish between malpractice and bad result.

I suggest, as a means of correcting this matter, the creation of a statute similar to the automobile no-fault statute that is now law in the State of Michigan, as follows:

A patient entering a hospital for medical care and treatment would be provided with the opportunity to secure "mal-occurrence" insurance by merely selecting it at the time of admission when and where consent forms are usually signed in the hospital record. This mal-occurrence insurance would provide an injured patient with compensation on a basis similar to compensation paid an employee who is injured on the job under the Michigan Workmen's Compensation Law. There would be no recovery for pain and suffering, but the payment would be made over a fixed period of weeks covering the hospital bills that would be incurred, medical bills that would be incurred, lost wages up to a certain percentage (if there were any in fact). A lump sum payment would be made for death, dismemberment, or permanency of injury.

The same policy could be in effect in the doctor's office. The patient would bear some of the burden for the payment of the premium in that his selection of this insurance would carry a nominal charge. It would seem to me that the courts would be interested for this would clear the crowded docket that malpractice litigation causes. A good malpractice case cannot be tried in less than two or three weeks.

This also would obviate proposed hearing panels composed of doctors and lawyers to adjudicate malpractice claims, which are only in effect, a dress rehearsal for the real thing.

A part of the overall malpractice problem, and I think a part that has to be brought home to the physician himself, is that the defense of a malpractice claim, no matter how spurious it may be, is expensive.

No one is getting rich on malpractice premiums. An $800,000 judgment, and there was one of those recently, eats up a lot of premiums paid by a good many physicians. The doctor should invest his time pushing the changes I have suggested above here, rather than carrying on a continuing fight with the carriers complaining about their rates, and for that matter, complaining about the inability to obtain malpractice insurance.

Finally, if you are sued and you know in your own mind you are right, don't settle the case. Force the plaintiff's counsel to trial. Malpractice cases, for plaintiffs, are the hardest kind of cases to try. They always have difficulty in finding competent experts. And tying up a plaintiff's attorney for three or four weeks in the courtroom with very little, if any, chance of recovery or payment for his services, will do more to discourage him from starting another one than anything else I can think of.

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In memoriam

Robert Bland Edmondson, MD
Grosse Pointe Farms

The former chief of staff at Bon Secours Hospital, Robert Bland Edmondson, MD, died Nov. 5 at the age of 57.

Doctor Edmondson was a graduate of Wayne State University School of Medicine and had practiced in northeast Detroit for 24 years. He was a native of Chicago and was a board diplomate of the American College of Surgeons and a founding fellow of the American College of Obstetrics. He also was affiliated with St. John Hospital.

Bowers H. Growt, MD
Addison

Bowers H. Growt, MD, Addison generalist for more than 50 years, died Nov. 11 at the age of 81.

Doctor Growt was the founder of the Addison Community Hospital, the first rural hospital in the state, and was honored with the naming of a Doctor Growt Week in Addison in June, 1971.

Following graduation from the University of Maryland Medical School, Doctor Growt served as a medical officer in World War I, then practiced in several small communities before moving to Addison.

In 1971, he received the MSMS 50-year award in Annual Session ceremonies. He was active in civic affairs and was a member of the American Association of Abdominal Surgeons. He also was a recognized artist and belonged to the American Physicians-Artists Association.

Frank Mercer, MD
Pontiac

Frank A. Mercer, MD, Pontiac physician for over 50 years, died Nov. 25 at the age of 84.

Doctor Mercer was affiliated with Pontiac General and St. Joseph Mercy Hospitals and was a past president of the Oakland County Medical Society. He also had served as president of the Pontiac Board of Education and as an honorary member of the Pontiac State Bank board of directors.

He was a fellow of the American College of Surgeons.

Ruth E. Preston, MD
Detroit

Lifelong Detroit resident Ruth Evelyn Preston, MD, died Nov. 11 at the age of 64. A graduate of The Woman's Medical College of Pennsylvania, she was affiliated with Hutzel Hospital, Detroit.

Doctor Preston was an internist and was a member of the American Heart Association.

Julian Stern, MD
Huntington Woods

Detroit-area urologist Julian Stern, MD, died Oct. 20 at the age of 49.

Doctor Stern was affiliated with Harper, Grace and Sinai hospitals in Detroit. He was a graduate of the University of Michigan Medical School. He was a member of the American Urological Association and was a Fellow of the American College of Surgeons.

He was a diplomate of the New Brunswick Medical Examiners and was a clinical instructor in urology at Wayne State University School of Medicine.

Donald A. Young, MD
Birmingham

Donald A. Young, MD, Birmingham, member of the Grace Hospital staff for many years, died Nov. 9 at the age of 64.

A graduate of Wayne State University School of Medicine, Doctor Young was a member of the American Academy of Family Physicians. He was a captain in the Army Air Corps during World War II.

Yearly figures from the State Board

Following are figures from the Michigan State Board of Registration on the number of doctors who hold permanent licenses, including residents:

1961	7,431
1962	7,714
1963	7,746
1964	8,043
1965	8,189
1966	8,307
1967	8,332
1968	8,379
1969	8,742
1970	8,759
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1972	9,090

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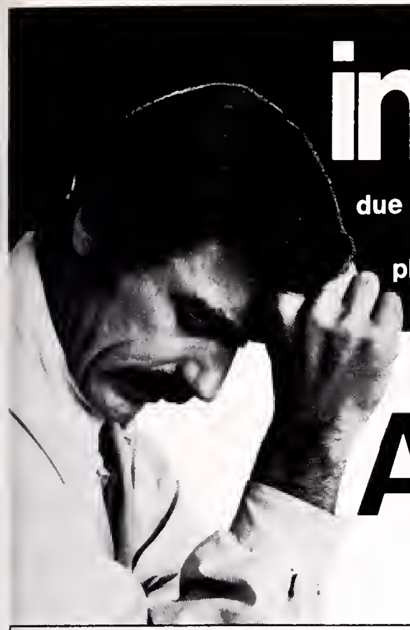

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Glutamic Acid ....50 mg.	Glutamic Acid ....50 mg.	Glutamic Acid ....50 mg.	Ascorbic Acid (Vit. C) .250 mg.
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References: 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12·69, 1966 2. **Dublin, M. F.** Treatment of impotence with methyltestosterone-thyroid compound West Med 5·67, 1964 3. **Titett, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25·6, 1962 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone J Clin Endocr 19·936, 1959 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79·863, 1958 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25) Lippincott, Philadelphia, 1955, p 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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1972 House of Delegates Proceedings

107th Annual Session

Michigan State Medical Society

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For your convenient use of the *Digest of Proceedings*, please note the following arrangement of contents:

Each report is followed immediately by the action of the reference committee on that report and then by the House action on the report of the reference committee. Resolutions are printed as they were finally approved or disapproved by the House.

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107th Annual Session
Michigan State Medical Society
Oct. 1-3, 1972

CALL TO ORDER AND SPECIAL REPORTS

1. Call to Order

The Annual Session of the House of Delegates of the Michigan State Medical Society, held at the Sheraton-Cadillac Hotel, Detroit, Michigan, convened at 2:00 p.m., Vernon V. Bass, MD, Speaker, and James D. Fryfogle, Vice Speaker, presiding.

2. Invocation

The Speaker called upon A. Stewart Kerr, the Parliamentarian, to give the invocation.

3. Report of Committee on Credentials

Chairman Keate T. McGunegle, MD, reported 104 delegates seated, the majority of whom were not from any one county.

4. Reports of the Committee on Rules and Order of Business

(a) Report of the Committee on Rules and Order of Business

Chairman Robert M. Stow, MD, reported that the Committee on Rules and Order of Business held its meeting in East Lansing on September 12, 1972. Speaker Vernon V. Bass, MD; Vice Speaker James D. Fryfogle, MD; and Secretary Kenneth H. Johnson, MD, were present as guests of the Committee.

Order of Business for 1972 Annual Session. The Committee reviewed and approved a draft of the amended Order of Business, for printing in the Delegate's Handbook. The Committee commends the Speaker for implementing Resolution 72S-3 of the 1972 Spring Meeting, which authorized that the first meeting of the House of Delegates be scheduled in the afternoon of the first session day and that the schedule be arranged to include a minimum number of evening meetings, except for the Presidential Inaugural.

Review of Resolutions Submitted after the September 1, 1972 Deadline. As authorized by Resolution 72S-2 of the 1972 Spring Meeting, the Committee and the Speaker reviewed one resolution that was submitted after the 30-day deadline prior to the commencement of the first meeting to determine whether it was urgent or important and should be received after the deadline. The Committee agreed to defer action and to hold a special meeting at 1:00 p.m. on Sunday, October 1, 1972, in the Speaker's Suite at which time it will consider this resolution and any additional resolutions submitted after the deadline date. The decision of the Committee on each resolution will be communicated to the House via the remarks of the Speaker at the opening meeting.

Request from Blue Shield to give Awards to Retiring Blue Shield Board Members. The Committee considered a request from Michigan Blue Shield to present awards to retiring Blue Shield board members who are members of the MSMS House of Delegates at the fall session. The Committee authorized the Speaker to grant this request and these awards will be presented as part of Item 22 of the Order of Business on Tuesday afternoon, October 3, 1972.

Authorization to Recess Proceedings. The Committee again recommends to the House of Delegates, as it has for the last three years, that the House vest in the Speaker the authority to recess its proceedings to a time certain, at his discretion, and without the necessity of the vote of the body. Such vesting of authority will constitute the only departure from Robert's Rules of Order, which we recommend otherwise govern the proceedings of the 1972 House of Delegates.

(b) Supplemental Report of the Committee on Rules and Order of Business

Chairman Robert M. Stow, MD, reported that the Committee on Rules and Order of Business held its second meeting in the Speaker's Suite on October 1, 1972, to consider several resolutions which were received after the September 1 deadline.

The first entitled: Commendation to Ingham County Physicians who care for the Legislators.

Committee Action: This resolution was not accepted. It was referred to the 1973 Spring Session as the number one resolution.

The second entitled: Shortage of Family Physicians.

Committee Action: This resolution was not accepted. It was referred to the 1973 Spring Session as the number two resolution.

The third entitled: Section of General Practice Name Change.

Committee Action: This resolution was not accepted. It was referred to the 1973 Spring Session as number three resolution.

The fourth entitled: Change of the Name of Medical Auxiliary.

Committee Action: This resolution was not accepted. It was referred to the 1973 Spring Session as the number four resolution.

The fifth entitled: A Resolution of Information for Physicians when they leave their community.

Committee Action: This resolution was accepted and will be 72A-27, and is being referred to Reference Committee C.

The sixth entitled: Study of Health Care in Michigan's Penal Systems.

Committee Action: This resolution was accepted and will be 72A-28, and is being referred to Reference Committee C.

The seventh entitled: Physician Manpower for Rural Areas.

Committee Action: This resolution was accepted and will be 72A-29, and is being referred to Reference Committee E.

The eighth entitled: Medical Malpractice.

Committee Action: This resolution was accepted and will be 72A-30, and is being referred to Reference Committee F.

The ninth entitled: The Drinking Driver Problem.

Committee Action: This resolution was not accepted. It was referred to the 1973 Spring Session as the number five resolution.

THE HOUSE adopted the report and the supplemental report of the Committee on Rules and Order of Business.

5. Speaker's Remarks—Vernon V. Bass, MD

The Speaker outlined the plans and procedures of the House. He announced the 1973 Spring Session will be held at Boyne Mountain, Boyne Falls, Michigan, Sunday, Monday and Tuesday, May 13-15, 1973, convening at 2:00 p.m. on May 13. He recommended that in selecting the 1974 Spring Session site that serious consideration be given to an out-of-state location, such as the Grand Bahamas or Nassau.

REFERENCE COMMITTEE C, John R. Franck, MD, Chairman, recommended approval of the Speaker's recommendation that in selecting the 1974 Spring Session site, serious consideration be given to an out-of-state location, such as Nassau or Grand Bahamas.

THE HOUSE approved this recommendation of the Reference Committee.

(The following reports of the Speaker were presented to the delegates in printed form.)

(a) Speaker's Report—1971 House of Delegates

This is a brief review of the implementation of resolutions adopted by the 1971 House of Delegates. (For complete text of resolutions with House action, refer to the Digest of Proceedings, *Michigan Medicine,* Vol. 70, No. 34.)

Res. 1—Quorum for MSMS House of Delegates. This resolution was disapproved.

Res. 2—Medicaid Performance, Surveillance, and Utilization Report System. This resolution was disapproved.

Res. 3—Appointment of Committee to Consider Two House Meetings a Year. A substitute resolution was adopted in lieu of Resolutions 3 and 4. The decision to hold two meetings of the House of Delegates—one in the spring and one in the fall has been implemented.

Res. 4—Change of Dates for Annual Meeting of the House of Delegates. A substitute resolution was adopted in lieu of Resolutions 3 and 4. See Resolution 3.

Res. 5—Establishment of Michigan State Medical Society Malpractice Judicial Panel. The House took no action on this resolution.

Res. 6—Establishment of a Uniform Fee Schedule for Medicaid Payment. MSMS has followed the development of House Bill 5305 and House Bill 5837, both of which would establish a uniform fee schedule for Medicaid payments. MSMS has advocated the uniform fee schedule based upon the 1971 Relative Value Scale with a 5-digit CPT and with an annual review of payments. The change from Blue Shield to the Department of Social Services of fiscal intermediary functions over Medicaid has created considerable dynamics, but no resolution has derived.

Res. 7—For Continuing Physician Education for Reregistration. This resolution called for the appointment of an ad hoc task force to study the issue of continuing medical education requirements for membership or relicensure and submit recommendations to the 1972 House of Delegates. This directive has been completed and the final report of the Ad Hoc Task Force on Continuing Medical Education will be submitted directly to the 1972 House of Delegates.

Res. 8—Drug Abuse. This resolution called for MSMS to urge a voluntary statewide moratorium by members on the prescription of amphetamines for diet control. A byline article by Richard C. Bates, MD, Chairman, MSMS Committee on Alcohol and Drug Dependency, appeared in the March 1972 issue of *Michigan Medicine* and a November 9, 1971, MSMS news release appeared in many newspapers.

Res. 9—Proxy Vote. This resolution was disapproved.

Res. 10—Restructure of MSMS Councilor Districts. This resolution was disapproved.

Res. 11—Responsibilities of MSMS President. This resolution was disapproved.

Res. 12—Relation of MSMS with Michigan Congressmen. MSMS has increased its contact with Michigan Congressmen, through MDPAC and the Department of Government Relations. Three trips to Washington by physicians and staff have tended to develop liaison with the Congressmen, and numerous telegraph and mail contacts have been made. On March 9, 1972, twelve members of the House of Representatives from Michigan, and Senator Hart attended a reception sponsored by MDPAC and partly supported by MSMS; on August 1 and 2 Michigan doctors met with Congressman Esch, Mr. Woolner from Senator Hart's office, and Senator Griffin. Continuing MSMS-to-Congress contacts are anticipated.

Res. 13—Summary of Medical Laws. The feasibility of a summary of medical laws has been considered by Legal Counsel, which finds it extensive and expensive. Further, the addition to medical laws at both the State and Federal level make such compilation obsolete within a year's time. The Council has taken no further action.

Res. 14—Homicide Prevention. Gun Control. Copies of Resolution 14 were circulated among the Executive of Michigan, the Legislature, and members of Congress. However, neither at the State or Federal level was effective gun control legislation enacted.

Res. 15—Physician Discrimination. The House took no action on this resolution.

Res. 16—No Fault Malpractice Insurance. Various means to relieve the malpractice insurance problem are under consideration by the Legislature, a special committee of the Legislature and its Advisory Committee, and through a cooperative series of meetings between medical and osteopathic physicians. A concept of no-fault malpractice insurance has been introduced to all of these groups. No definite program for malpractice insurance really has developed.

Res. 17—Computer Committee. An MSMS Committee on Computers has been appointed, as directed by this resolution, with Robert M. Stow, MD, of Lansing, as its Chairman.

Res. 18—Studded Snow Tires for "Emergency" vehicle. This resolution was disapproved.

Res. 19—Institution of Legal Action Against the State of Michigan. This resolution calls upon the MSMS to reaffirm its commitment to require the fiscal intermediary for Medicaid to pay for services as usual, customary and reasonable rates. This resolution was considered in context with Resolution 6 calling for a uniform fee schedule. Extensive conversations with State officials have taken place as the State Department of Social Services assumed the fiscal intermediary functions from Blue Shield. Adjustments in rates have been promised by the Department, to "track" Medicare rates.

Res. 20—Contract with Michigan Department Social Services for Medicaid Services. Substitute resolution adopted in lieu of Resolutions 6 and 20. See Resolution 6.

Res. 21—Prohibition of Inequitable Prorating of Payment for Medicaid Services. Substitute resolution adopted in lieu of Resolutions 19, 21 and 27. See Resolution 19.

Res. 22—Lansing as the Annual House of Delegates Meeting Site. The House took no action on this resolution.

Res. 23—Effort to Repeal or Modify MMS Enabling Act. This resolution was disapproved.

Res. 24—Revision of Pharmacy Rules. The MSMS Council, April 26, 1972, pursuant to this resolution and a recommendation of the Liaison Committee with the Michigan State Pharmaceutical Association, adopted a position statement that registered nurses should be permitted in hospitals to dispense medication ordered by a qualified physician in the absence of a registered pharmacist. This position was circulated to the Pharmaceutical Association and the Michigan Nurses Association. Both groups reacted strongly against this position. Board of Registration in Pharmacy has not acted to amend the rules nor was MSMS notified of receipt or hearings scheduled.

Res. 25—Defense of Physician by Michigan State Medical Society. This resolution was referred to the Committee on Utilization Review and Health Insurance Problems which acts as the final appeal body on peer review matters. The Committee reports that the intent of this resolution is incorporated in the "Guidelines for MSMS Peer Review Program."

Res. 26—Non-participation in Blue Shield Provider Contracts. This resolution was disapproved.

Res. 27—Payment of Usual and Customary Fee by Medicaid Fiscal Intermediary. Substitute resolution adopted in lieu of Resolutions 19, 21 and 27. See Resolution 19.

Res. 28—Consumer Committee. This resolution instructed MSMS to urge component societies to appoint local consumer committees to help present the medical point of view, and for MSMS to select a statewide committee from the membership of the component-sponsored committees. Articles appeared in *Michigan Medicine* and a letter was sent March 15, 1972, to each component society by the MSMS Committee on Public Relations. Committee members also conferred with some of the component presidents. As of September 1, 1972, MSMS has received no information from any component society that such a committee has been established or is functioning.

Res. 29—Discrimination against Physicians and Women in Membership on County Hospital Boards. The provisions in law preventing physicians from serving on the boards of county hospitals and limiting the number of women on the board were repealed by House Bill 4902. The objective of this resolution has been achieved.

Res. 30—Increasing Hospital Construction Costs. In February, representatives from the Michigan Hospital Association and the Michigan Association of Osteopathic Physicians and Surgeons met with MSMS and discussed this resolution. A subcommittee with representatives from each group was named to puruse the matter. The subcommittee had not reached conclusions as of this date.

Res. 31—Reporting Medical and Surgical Care to Insurance Companies. This resolution is under active study by the Computer Committee as part of its broad charge to keep abreast of developments in computerized medical record systems.

Res. 32—Laboratory Service for Comprehensive Drug Abuse Treatment Programs. This resolution was referred to the Committee on Alcohol and Drug Dependency. On January 25, 1972, a communication was sent to the Governor's Office of Alcoholism and Drug Abuse, requesting its help in devising a way in which tests to obtain laboratory analysis of street drugs can be run at cost.

Experience in other states has shown that one of the most valuable components of a program to combat drug abuse is free access to a laboratory equipped to identify the composition of unknown drugs, test body fluids for levels of drugs and run tests on the urine of methadone patients to determine that they are taking the methadone and that they are not taking other drugs.

Res. 33—Application of the "Good Samaritan Law" to physicians forced to service the Emergency Room by Hospital Bylaws. This resolution was disapproved.

Res. 34—Abolition of Seven Year Limitation of Service Connection Classification of Veterans Disabled by Multiple Sclerosis. This resolution was disapproved.

Res. 35—Revision of Present Geographical Determination of Michigan Variable Fees. The House took no action on this resolution.

Res. 36—Unsatisfactory Federal Narcotic Registration Form. This resolution directed the Michigan Delegation to urge the American Medical Association to work toward simplification of the Federal Narcotic Registration Form.

The Delegation introduced a resolution at the November 1971 AMA meeting, requesting AMA to petition the Bureau of Narcotics and Dangerous Drugs to develop a less complicated form and the resolution was adopted by the AMA House of Delegates.

Res. 37—Physician Participation with Third Parties. A resolution adopted by the House of Delegates in the Spring Session directed the MSMS Council to consider the feasibility of developing a single insurance claim form that can be used or altered by third-party carriers. In separate action MSMS Council Chairman appointed an Ad Hoc Committee consisting of the President, President-Elect, the Chairman of The Council, and the Treasurer to deal directly with the State on matters of Medicaid.

Res. 38—Definition of a Specialist. This resolution defined a specialist and was made a part of the Official Policies of MSMS.

Res. 39—Higher Reimbursement by Blue Shield for Outpatient Surgery Performed in the Surgeon's Office. This resolution was referred to the Committee on Utilization Review and Health Insurance Problems. The Committee reports that as of September 1, 1972, Blue Shield will be capable of reimbursing physicians for work done in their offices according to office charging patterns and if their charge patterns are different from like procedures performed in the hospital, they will be reimbursed accordingly.

Res. 40—Recommendations for Peer Review. This resolution was referred to the Committee on Utilization Review and Health Insurance Problems which acts as the final appeal body on peer review matters. The Committee reports that the intent of this resolution is incorporated in the "Guidelines for MSMS Peer Review Program."

Res. 41—Blue Cross-Blue Shield Coverage for Medical Students. This resolution was studied by the Committee on Professional Insurance Plans. The Committee reported that medical students and their dependents can obtain adequate health care and health insurance through the universities and there is no need to extend coverage to them through the MSMS Group 94000 Blue Cross/Blue Shield program. The recommendation of the Committee was approved by The Council on June 6, 1972.

The Committee also noted that the only way medical students could become eligible for the MSMS group would be if they became MSMS members. (There are no provisions in the current MSMS Bylaws for students to become members.)

Res. 42—Direct Payment to Medicaid Patients. Since the inception of the Medicaid Program, MSMS has constantly tried to convince State authorities that payment processes under the Medicaid Program should equate to those under Medicare. State authoritiees remain adamant on this issue, although this calendar year benefits for Category 2 patients were increased equal to those of Category 1.

Res. 43—Direct Payment of National Health Insurance Funds to Patients. This resolution was referred by The Council to the Michigan Delegation to the AMA. The Delegation introduced a resolution at the November 1971 AMA meeting to "encourage future federal health programs to permit billing of patients by physicians and allow federal payment of funds to patients when patient and physician agree." The AMA House of Delegates adopted the resolution.

Res. 44—National Health Insurance Legislation. The House took no action on this resolution.

Res. 45—Elimination of Delegate to Councilor. This resolution was disapproved.

Res. 46—Insurance Coverage for Voluntary Sterilization. Adopted Resolution 65 as amended as a substitute for Resolution 46. See Resolution 65.

Res. 47—Exoneration of a physician from Conspiracy in the assassination of a President. The contents of this resolution with the resolved clause have been brought to the attention of the members of the Michigan Delegation to Congress and to the Senators.

Res. 48—Home Health Services Under Medicare. The need for increased home health services has been brought to the attention of political leaders at the State and National level. The new Practitioner's Manual under State Medicaid program provides for part-time nursing services, home health aid services, administration of oxygen, and eligible physical therapy rendered by a home health agency —only with recommendation and authorization of the medical practitioner.

Res. 49—Membership Priorities. This resolution suggested a poll of MSMS members to determine their opinions of issues, etc. No immediate action was taken because AMA was planning the same kind of survey and it was felt that MSMS should not ask the same questions. The AMA questionnaire was mailed March 31, 1972. There were 94,035 replies or 52.9 percent, which was viewed as an excellent return.

Survey results were reported to the AMA House of Delegates last June. An AMA report contrasting Michigan responses to the national totals was received at MSMS headquarters September 1 and will be distributed to the MSMS House of Delegates. The summary reports the view of Michigan physicians on such issues as principles of practice, national health insurance, professional liability insurance, manpower supply, AMA services, etc.

Several other states are beginning to survey members re opinions and attitudes and MSMS is requesting information about their questions, procedures, etc. MSMS interprets Resolution 49 as being an ongoing policy decision. A survey is being planned for December for distribution through *Medigram* to reduce postage costs.

Res. 50—$25.00 Re-Registration Fee. This resolution was disapproved.

Res. 51—Nomination of Members of the Corporate Body of Blue Shield. This resolution was disapproved.

Res. 52—Physician Relations with Communications Media. This resolution urged MSMS members to work closely with local news media. An article implementing this resolution appeared in the February 1972 issue of *Michigan Medicine.* A copy of the resolution appeared on the back cover of the Michigan Press Association journal to newspaper editors in June 1972 as a paid MSMS message, urging greater teamwork between newspapers and physicians.

Res. 53—Recognition of Physician's Services to MSMS. This resolution authorized the Speaker to develop suitable means of recognition for physicians who have given unselfishly of their time and talents on the MSMS Council, in the MSMS House, and other significant positions. The Speaker will make some recommendations to the 1972 fall House regarding this award.

Res. 54—Emigration of Medical Graduates. This resolution authorized the appointment of an ad hoc committee to investigate reasons why some medical students leave Michigan and to make recommendations to minimize this loss. The members of the Education Liaison Committee and the Liaison Committee with Medical Students were appointed as the ad hoc committee. The matter was discussed at two ad hoc committee meetings, and the three medical schools began considerable research about their graduates. The medical schools have contributed much time and some funds for statistical research and interpretation. The ad hoc committee, at its meeting August 31, 1972, agreed to ask the House for an extension of time to complete the study. Several representatives of the MSMS committee have been appointed to confer with the medical school representatives to draw up possible recommendations. The ad hoc committee plans to report to the March session of the MSMS House.

Res. 55—Change of DSR Reporting Forms for Blue Shield. This resolution was referred to the MSMS Committee on Utilization Review and Health Insurance Problems which has the matter under continuing discussion with Blue Shield representatives.

Res. 56—Surveillance and Utilization Review. This resolution authorized continued MSMS participation in the Medicaid Performance, Surveillance and Utilization report system and MSMS representatives have continued to function as members of the Advisory Committee to the program.

Res. 57—Smoking During Meetings of the Michigan State House of Delegates. This resolution was disapproved.

Res. 58—Appointment of Physician Members to the Corporate Body of Blue Shield. This resolution was disapproved.

Res. 59—Drug Abuse Control. The Legal Affairs Committee followed legislation closely to enhance a control of drugs and narcotics in Michigan. MSMS actively supported House Bill 4882 which established a State Bureau of Narcotics and Drug Control, one factor of which is the keeping of an inventory by all practicing physicians of dangerous drugs in their possession. House Bill 5856, a bill designed to offer addicts the alternative of obtaining clinical help rather than imprisonment, was reviewed by the Committee on Drug and Alcohol Dependence. On-going contact in the development of this piece of legislation continues.

Res. 60—Medicaid Provision for Preventive Health Care Services. Although not all preventive services are yet covered in the new Medicaid program, certain significant additions to services covered have been added. Among these are immunizations, Pap smears and prosthetic devices on an out-patient basis.

Res. 61—Delay by Michigan Blue Shield in Payment of Physician's Services Rendered. This resolution was referred to the MSMS Committee on Utilization Review and Health Insurance Problems which has the matter under continuing discussion with Blue Shield representatives.

Res. 62—Support of Proposed Policy declaration on Maintenance of Health and Medical Care of National Chamber of Commerce of the United States. This resolution directs The Council to stay abreast of the National Chamber of Commerce proposed health policy. In addition to AMA's proposed "Medicredit" health insurance measure, MSMS has kept abreast of the Chamber of Commerce proposal, the health insurance industry's proposal, and certainly the Kennedy-Griffith proposal. Included in the Chamber of Commerce contacts are membership in the National Chamber of Commerce and a one-hour visitation at the National Chamber of Commerce Health Office in Washington.

Res. 63—Medical Education Community Orientation (MECO) Project. This resolution asked that MSMS strengthen its support of the SAMA-MSMS-MHA-MAFP project to place sophomore medical students in community hospitals. The MSMS Department of Communications provided additional staff leadership to this project and 92 students from the three medical schools were placed in 51 communities during the summer of 1972. There also was much more newspaper publicity, etc., than in 1970 when 11 students were placed, or in 1971 when 50 students participated.

Res. 64—Shortage of Physicians. MSMS played a role in the legislative appropriation of funds which will increase total class sizes in Michigan medical schools in 1972 by 221 students. Major gains are 54 students at the Michigan State University College of Human Medicine, 111 students at the Wayne State University Medical School and 50 students of the University of Michigan Medical School. The remaining gain is at the School of Osteopathic Medicine at Michigan State University.

Res. 65—Payment for Voluntary Sterilization. This resolution reaffirming the MSMS policy supporting third party payment for elective sterilization was forwarded to the Michigan Insurance Commissioner as instructed. Copies were also sent to all members of the Michigan Medical Service Board of Trustees.

Res. 66—Abortion Reform Petition Drive. A single mailing to doctors in Michigan, bringing to their attention the abortion reform petition drive, was made from MSMS headquarters. It informed doctors who are interested in the petition drive how they could participate. The matter of abortion reform will be on the November state ballot.

Res. 67—Support of Abortion Reform Referendum in 1972. This resolution was disapproved.

Res. 68—Financial Aid to Medical Students. This resolution was disapproved.

(b) Speaker's Report—Spring 1972 House of Delegates

This is a brief review of the implementation to date of resolutions adopted by the 1972 Spring Session House of Delegates. (For complete text of resolutions with House action, refer to the Digest of Proceedings, *Michigan Medicine,* Vol. 71, No. 24, August, 1972.)

Resolution 72S-1 Separate Councilor for Oakland County. The House took no action on this resolution.

Res. 72S-2 Submission of Resolutions. This resolution required that resolutions to the MSMS House of Delegates generally be submitted thirty (30) days prior to the commencement of the session at which they are to be considered and authorized the Speaker and the Committee on Rules and Order of Business to determine which resolutions are either urgent or important to be received after the deadline for presentation. Both of these items have been incorporated in the Order of Business for the 1972 Annual Session.

Res. 72S-3 Meetings of the House of Delegates. This resolution resolved that the schedule for the House of Delegates be arranged to include a minimum number of evening meetings except for the Presidential Inaugural. This has been incorporated in the Order of Business for the 1972 Annual Session.

Res. 72S-4 Seating of Delegates. These Bylaws changes regarding the seating of delegates were laid over to the Fall 1972 Meeting of the House and will be reported to the House in the Report of the Committee on Constitution and Bylaws.

Res. 72S-5 Establish Reimbursement for Levels of Care. This resolution called on MSMS Legal Affairs Committee to seek changes in Federal and State legislation regarding payment of extended care costs and to seek changes at the National level through AMA action. The Michigan Delegation introduced a resolution at the AMA convention in San Francisco urging AMA to continue in its efforts to resolve problems of adverse regulatory decisions concerning Title XVII and XIX and this resolution was adopted as AMA policy. At the state level the issue had been referred to Legal Affairs Committee which has made no progress yet.

Res. 72S-6 Reassessment of American Medical Association Structure and Function. This resolution supported the reassessment of AMA structure, function and purpose which is now being carried on by the AMA Committee on Long Range Planning and Development. Both The Council and the Michigan Delegation to the AMA have been involved in this, and a hearing of the AMA Committee is being held during the Fall 1972 meeting of the MSMS House of Delegates.

Res. 72S-7 Obstetrical Department Utilization. The Committee on Maternal and Perinatal Health, and its Subcommittee on Better Utilization of Obstetrical Beds, considered Resolution 72S-7 and a special report on the Committee's recommendations was sent to the members of the House of Delegates in the mailing of September 20, 1972.

Res. 72S-8 Sub-Specialty Certification in Radioisotopic Pathology by the American Board of Pathology. The House took no action on this resolution.

Res. 72S-9 Electromyographic Needle Electrode Examinations. This resolution has been referred to the Committee on Utilization Review and Health Insurance Problems for transmission to Blue Shield and Commercial Health Insurance Companies.

Res. 72S-10 Medical Foundation Principles. The House took no action on this resolution.

Res. 72S-11 AMA Membership Hearings. MSMS has invited the AMA Council on Long Range Planning and Development to hold hearings on October 2, 1972, in conjunction with the 1972 Annual Session. The subject areas for the hearings are (a) proposed changes in the AMA Constitution and Bylaws (b) the organizational structure of the AMA (c) deliberation of AMA Committee and Council responsibilities and (d) other suggestions designed to improve the role of the AMA.

Res. 72S-12 Peer Review to be Performed by the MSMS. The House took no action on this resolution.

Res. 72S-13 In-Hospital Family Planning Education. This resolution may be considered by the MSMS Committee on Hospital Relations. Mailing lists are being assembled to send the resolution to those named in the Resolved portion of the resolution.

Res. 72S-14 Call for Referendum on Question of Medical Programs, Inc. This resolution was disapproved.

Res. 72S-15 Relative Value Study Committee Report (Medicine Section). This resolution approved the RVS as presented by the Relative Value Study Committee and recommended its usage. The RVS is now being printed with five-digit coding and four-digit coding where applicable and will be supplied to all MSMS members when it is available.

Res. 72S-16 Proscription of MSMS Role in Blue Shield Activities. The House took no action on this resolution.

Res. 72S-17 Resolution Supporting the Concept of Certificate of Need Legislation and Urging Passage of Such Legislation. The House took no action on this resolution.

Res. 72S-18 A Separate Charter for Gratiot County as a Component County Medical Society. This resolution was referred to The Council for investigation and recommendation. The Council's investigation of this resolution revealed that concurrence of the physicians in the Gratiot-Isabella-Clare area in the intent of this resolution could not be reached at this time. Therefore, The Council is unable to recommend action on this matter. However, it is noted that a resolution on this subject has been introduced in the Fall 1972 House of Delegates so that the House may consider it further.

Res. 72S-19 Medicaid Payment for Patients with Psychiatric Diagnosis. Though some gains have been made for psychiatric coverage in the new Medicaid program, the objectives of this resolution have not been fulfilled and it has been referred to the Legal Affairs Committee.

Res. 72S-20 MSMS Support for Bill for Sex Education and Teaching Birth Control. This resolution calls for MSMS to support legislation which would change the sex education law to allow the teaching of birth control. A bill to permit birth control education in the public schools of Michigan has passed the Michigan State Senate and is referred to the Committee on Education of the House. Positive action is unlikely.

Res. 72S-21 Teen-Age Contraception. A bill to permit physicians to provide birth control advice and devices to minors without parental consent has passed both Houses of the Legislature in different forms, and now is in Conference Committee. The Conference Committee is deadlocked. MSMS Department of Government Relations is attempting to develop a compromise.

Res. 72S-22 Blue Shield Payment for Elective Sterilization. This resolution requested that MSMS work with Blue Shield to accomplish change in policy so that Blue Shield will pay for elective sterilizations. This matter has been referred to the MSMS Committee on Utilization Review and Health Insurance Problems which has it under discussion with representatives of Blue Shield.

Res. 72S-23 Changes in Workmen's Compensation Rules and Regulations. This resolution urged revision of Workmen's Compensation laws to encourage employment of the handicapped without the employer incurring unfair responsibility for naturally occurring disease processes or aggravation of pre-existing conditions, by a waiver mechanism. The resolution has been referred to the Committee on Legal Affairs for appropriate implementation.

Res. 72S-24 MSMS Condemnation of Blue Shield Form 968—Pay Subscriber Form—Blue Shield Form 5505. This resolution has been referred to the Committee on Utilization Review and Health Insurance Problems for study and implementation.

Res. 72S-25 Medical Treatment of Neurologically Abnormal Children by Non-Physicians. This resolution would have MSMS remind the State Board of Education and State Boards of Registration of Licensed Therapists relative to programs for neurologically disabled children that prescriptions and modalities of treatment properly belong under the direction of physicians. This has been referred to the Legal Affairs Committee.

Res. 72S-26 Regional Election of AMA Delegates and Alternates. The House took no action on this resolution.

Res. 72S-27 Physician Liability for Payment of Patient's Hospital Bills. This resolution has been referred to the Committee on Utilization Review and Health Insurance Problems.

6. President's Address — Sidney Adler, MD

This report is directed to all my colleagues whether they are young chronologically or physiologically.

In our confusion regarding the various health plans propounded in Washington, D.C. and across the nation by political parties and their various factions, by other groups both within and without our profession (including hospitals and consumer groups) I am reminded of Abraham Lincoln's House divided speech in June, 1858:

> "If we could first know where we are, and whither we are tending, we could better judge what to do and how to do it."

We physicians are dissatisfied and distrustful of administration but are unwilling to function effectively as administrators (whether we have the capacity is another question) mainly, I think because it is wasteful of our time and talents. But we must do much more in research and development in order to assess and improve the standards of health care.

I have studied and discussed this with my colleagues at the county levels, counsellor districts, state, national, and foreign health care levels. There seems to be a reluctance of physicians to have their work reviewed—scrutinized if you will, by their own colleagues and by government health agencies. Secondly, there is great difficulty of devising methods for measuring high standards of health care. The responsibility to their patients seems to be their only responsibility. Really, most consumers of health care lack the knowledge to make competent judgments. They need information in order to have reason and judgment in their determination of what form of health care is best for themselves and the nation at large. We have not given the consumer this data. Therefore, most of them are enmeshed in political expediencies and ploys.

We are all for progress but very slow in accepting changes. (How does one have progress without change?) Changes upset everyone's behavior patterns, philosophies and ways of life. Flexibility rather than rigidity must come to the forefront.

When I accepted the office of President of our Society, I tried to warn you of some of the threats to our profession and to our professional freedoms which we face. Factions within and without the profession seek to involve our Society in political, social, and economic causes and campaigns. I urged that we had enough to do if we concerned ourselves with the science and art of medicine, and left politics to the politicians, social causes to the social workers, and economics to the economists.

If that was a fitting note upon which to begin my term, it is an equally fitting note upon which to end it, for the trend has accelerated, not weakened in force, during my tour of duty.

This Society must represent physicians. As physicians, our first concern should be promotion of the science of medicine and achievement of the highest standard of patient care. We deliver that care in different ways; some in hospitals, some in group practice units; some in one-man offices. The Society should represent all of us, without discrimination or favor. Patient care, not the choice of a way in which to deliver it, should be the prime business of the Society, leaving each member free to practice under whatever delivery medium he chooses, so long as he is ethical and takes good care of his patients.

I fear that the effort of politicians and social workers, with the aid of some of our colleagues, to make organized medicine responsible for delivery systems may, if it is successful, destroy private medicine. Organized medicine must represent all of us, not selected factions among us. If we allow ourselves to be split into geographical, political, sociological and economic groups, to be divided according to our ideological (as contrasted with our professional) interests and concerns, our Society may become (as in some foreign countries) an instrumentality for the regimentation of physicians.

I am not oblivious to the needs of the poor of the community. Physicians always have been acutely aware of those needs, and served them freely long before there was a Department of Health, Education and Welfare in the Federal Government. They should continue to be active in political and social causes, and they will be. My point is that this should not be the business of organized medicine; it should be, as it once was, the business of like-minded physicians who band together for the purpose.

Government, great charitable foundations, and social agencies have dangled the bait, in the form of grants and payments, and all too often we have risen to it and at times, grabbed the loot without adequate appraisal of the cost. Much of the time, the cost has been high. We may be approaching the point of no return.

Alexander Grant Phase II Study

Happily, the review of this report is in the hands of a committee headed by Dr. S. Gould. The report of committee reveals much work in the confusing data that was presented to them. It takes a psychiatrist like him to help keep the planning and practice group from becoming a manic depressive in attempting to find any rhyme and reason out of the "study."

I have a suggestion to make after two years as president-elect and as president. I would ask the committee and this House of Delegates to consider the feasibility of having the president that you elect to be the chairman of The Council, the president-elect become vice-chairman. This would give the Michigan State Medical Society stronger leadership and continuity in following the decisions made by this House of Delegates. These two men would be able to visit all of the county medical societies and know the local problems. This perhaps would eliminate some of the petty misunderstandings and provincialism. Also, they would be better able to track and follow the various and sundry committees of our Society. Another suggestion would be that Michigan State Medical Society employ a full time physician as medical director, thus a physician can best relate to another physician.

Provincialism is good. It gives our society a grass roots expression of the philosophies and ideas of its members. Provincialism also exists among various and sundry speciality societies. It starts in one's own family and expands to groups, states and national societies. We must be careful not to build empires within empires. The day is long gone when we can afford the luxury of medical politics by pitting the outstate against the large urban areas, particularly in considering the fundamental issues of all physicians who are members of the society. Mobility of populations and physicians should have eliminated a great deal of the old regional "hang-ups." It must be receptive to all ideas, concepts and philosophies expressed by its members.

Mine is a solo practice of medicine. I don't want to be told and I don't want anyone to tell me where to practice, what hours to practice, whom my patients should be, how much I should charge them (except to avoid unethical gouging or deception), what method of treatment to employ when accepted methods offer a choice, or how to choose my friends and associates. I have no quarrel with my colleagues who elect to practice in groups or institutions under rules governing some of these subjects. The choice is theirs, and they are free to leave their offices and to join an institution. What I say is that the choice should be that of each of us, and that it is no business of organized medicine to concern itself with that choice. It should represent us all equally well.

Office holders sometimes seek to entice us with the plea that they need help. In some instances the appeal may be legitimate. Often, however, it is power and not help that they seek. I greatly fear that unless our Society can learn to say no when asked to become involved in a problem which is not properly its concern, we will, in fact, find ourselves organized and regimented, and our Society employed as a means to that end. The present Medicaid impasse is an illustration. The state officials seek to radically alter the relationship of physicians to the Department of Social Services.

They first told us that this was required by law—it just isn't.

They told us that it had to be done to make Medicaid work to reduce costs of its administration. It just does not and it won't.

They told us that it would reduce paper work and shorten the time of payment to physicians. It, in fact, would have the opposite effect.

I have been fighting to keep things as they have been under Blue Shield's administration as fiscal agent. As an officer, I shall continue to do so.

I have opposed and shall continue to oppose any prior agreement to whatever fee schedules and reporting requirements the Department may see fit to impose. How does a physician sign an agreement without studying the manual. *It is sign or don't get paid.*

They told us it was the only way to verify the physician's signature. It just isn't so. It is discriminatory to the Medicaid patient. They must now go to a physician who agrees to sign a prior agreement. Published lists will soon be available to the hospitals and the public. I shall continue my opposition.

I have opposed a reporting form with 107 items of required insertions by the physician in order to complete it. I shall continue to oppose it.

This is a mandatory edict rather than participation on an individual case basis (all of our forms are on an individual case). However, if any of you want to sign this sort of thing, you are welcome to it.

Priorities

1. Cohesiveness in representing all segments of our members for a high standard of medical care for all patients. We must act rather than react to the myriads of plans advocated by those outside the practice of medicine.

2. The time is long past when we can afford the luxury of discussing and studying Peer Review. Years ago we set up funds for studying patterns of use of medical care, utilization and frequency of use patterns. Again, I ask how well do we practice medicine in the state of Michigan. If the government (federal or state) pays for this care they may insist on consumer participation in these areas.

3. Public Relations or how we relate to the patient and the public. To assure the patient, large consumer groups, government, etc., that their monies are well spent for a high standard of care, physicians must assure the public that their dollars are well spent. After all, it is the public that votes, not the political parties.

3A. I realize that on no one subject will all physicians agree and most assuredly on the role of government regulations of health care. I recommend no opposition to governmental ideas without offering better programs. Concerned and meaningful involvement both in numbers of physicians and factual data as a base level, if that is at all possible. Comprehensive Health Planning must be physician-oriented to perform its function at the local and state level. Identify where the physician plays a role and actively pursue that function.

4. Continuing Medical Education—now beginning to be called re-licensure of physicians on a 2-3-4 year basis.

   This determination *must* remain in the hands of physicians both as to its quantity and quality. It must be a joint cooperative endeavor of our physicians (whether hospital based or not), our specialty groups and medical schools.

   It is my belief that it does not belong in a State Board of Registration for Doctors, no matter how good their abilities or intentions.

5. Such things as economic remuneration to physicians, health manpower, physician-hospital relationship and cooperation, Foundations (whatever that means), nursing profession, nursing homes, etc., I believe become corollaries rather than axioms in our priorities.

One probably cannot gain popularity by challenging the rightness and goodness of utopian ideals, and so our leaders often remain prudently silent. But since Plato, those who have envisioned a utopian society also have envisioned an authoritarian society. Imprudently perhaps, I choose to raise my voice in protest. Maybe I will lose the freedom I prize, but I don't want the Society to be the instrument by which it was lost.

REFERENCE COMMITTEE D, Thomas R. Berglund, MD, Chairman, recommended (1) that President Adler's recommendation that the President be Chairman of The Council and the President-Elect Vice-Chairman of The Council be referred to the Planning and Priorities Committee, and (2) that the President's recommendation that MSMS employ a full-time physician as medical director be referred to the Planning and Priorities Committee with the further suggestion that this physician not be hired in the role of an administrator.

THE HOUSE adopted the report of the Reference Committee.

7. President-Elect's Address — John J. Coury, MD

One would think that after 25 years of medicine and 15 of those actively involved in MSMS, that accepting the presidency of this organization could be easily taken in stride. May I assure you that it is a most sobering affair.

When I reflect upon this issue, I realize that I am to represent over 8,000 members of this Society who are highly motivated, intelligent, independent and individualistic.

Accepting the presidency of the MSMS is indeed an honor and I will accept it with humility. It is also a real challenge and I accept this with determination.

No matter how great this organization may be, I pledge you I am dedicated to making it greater. With good health, your help and God willing it will be so!

Like any strong democratic organization, we are "open and above board," thereby subject to criticism and challenge because of our openness and individuality. We do not object to responsible criticism. It has helped us improve our organization and our service to our patients. We do object to irresponsible criticism from within and without our profession because it requires much time and effort to correct a wrong done to a great and dedicated organization—your Medical Society.

Despite this, we must meet these irresponsible charges so that the public and our patients may better understand that *these are* irresponsible criticisms! To do this, we must be organized! We must be unified! And *unity* is what I'm dedicated to!

During the past few years and particularly this past year, I have had the opportunity to visit many county societies and other medical organizations. I have listened to and observed the action of many members of our Society and our profession. During this time, I have learned much that can be put to use by our Society.

In addition, I have visited this spring with physicians under 45 in Kalamazoo, Lansing and Mt. Clemens. Hopefully, I can continue to meet with various segments of our Society, as well as large hospital staffs, interns, residents and medical students. I hope to learn what they expect of organized medicine, what they can contribute to organized medicine, why they are or are not members, and what we can do to unify our profession.

Often I've asked myself, Where are we going? Are we making progress? Have we made progress? What are our goals and purposes for the future? What really are our responsibilities to our patients and colleagues? Are we meeting our obligations?

On occasion, I have been discouraged. However, when I look back over the last 10-12 years, I can truthfully say that much progress has been made by your State Medical Society. We have been an active organization, responsive to our patients and our colleagues. Many of our critics deny this, stating that we are moving too slow. Others state we are moving too fast.

Though we have gone forward, we have farther to go. Forward in a constructive, reasonable and responsible fashion—not at an irrational and irresponsible pace as some would have us do.

We need input from every physician who is practicing medicine, not just those in this House of Delegates. We need input from every physician in this organization! Every member of our profession in this state, be he black or white, academic or private, should be a member of this organization.

We must have a strongly organized and unified profession if we are to continue to go forward: if we are to accomplish our goals!

I am convinced that what our organization needs today is *unity* in the profession. Unity can be obtained by active participation of all members of our profession, by reasonableness and a strong democratic organization.

We are all individuals and many times permit our individualism to override the common good of our organization.

When we were given life on this earth, we were destined to be "individuals." Since that birth, we have been continuously groomed to be "individuals," to be independent thinkers and to make difficult decisions of life and death. As doctors, we have been challenged by the most horrible of diseases and the most gruesome of accidents.

This individuality has made us strong and capable. This has been good for our patients and has made us a strong profession, envied by many. But this same strong individuality has been a deterrent to our being as strong and unified a profession as we should be.

There is no question that we are in this profession because we are "individuals." Individuals, strong enough to make difficult, important decisions. However, in our own democratic organization when our goals are common in nature, our individualism must be tempered with reasonableness, and for this I plead to you. We cannot afford the luxury of individualism in an organization that has a common goal for all. In a democratic organization when a majority decision is reached, then I feel it is the responsibility of all members of this Society to work toward the common goal. We may retain our individual differences, but we cannot permit parochialism, or fractionalization of our members to the detriment of the profession as a whole: to the detriment of our patients! In this respect, we must work toward a common goal. We must be tempered in our judgment and reasonable in our decisions.

How can we subordinate our individual freedom? How can we accept group decisions? I say to you, and I challenge you, it must be on the basis of the people that you elect to represent you. All members of this Society, in an official capacity, must be elected for the qualities they possess and the devoted effort that they will give to this Society. All should be elected on a quality basis. All must be elected for what they can do for Michigan medicine. When elected, they then should be granted the confidence of its members.

I ask you that your actions also be directed to what is best for Michigan medicine as well as what is best for you or your Society or your hospital. I ask you to broaden your sights, deepen your thinking, increase your activity to the point of sacrifice in order to make this a more viable organization.

We must dedicate our future to recruitment and unity. All of our profession must be brought into the mainstream of medicine. For only with a strongly organized and unified medical profession can we deliver the highest quality of medical care.

If we permit others than physicians to direct the course of medical care for the future, then we can surely expect a rapid decline in the quality of medical care that will be delivered to our patients. History has taught us this. Let us remember it!

The high quality of medical standards in this country were originated and amplified by organized medicine, the AMA, MSMS and county societies.

I repeat, to maintain our high quality of medical care, we *must* devote our efforts to recruitment and unity with the end result being a strongly organized democratic society.

Therefore, I give you these challenges—

I challenge you to become more involved.

I challenge you to get the uninvolved involved.

I challenge you to make members of non-members.

I challenge you to work for the common goal in a democratic organization.

I challenge you to improve your personal image—no matter how good it may be.

I challenge you to help unify our profession.

It will require hard work from all of us. I am willing! Are you?

REFERENCE COMMITTEE D, Thomas R. Berglund, MD, Chairman, recommended approval of the recommendation that President-Elect Coury's remarks be accepted, that everyone be encouraged to read and accept his listed challenges with particular emphasis on the challenge to get the uninvolved involved, and urged that the list of challenges be circulated.

THE HOUSE adopted the report of the Reference Committee.

8. Report of the Judicial Commission — C. Allen Payne, MD, Chairman

Following the last meeting of the House of Delegates, Chairman Donald N. Sweeny, Jr., resigned because of his gaining a seat on The Council of MSMS as Chairman of the Michigan Delegation to the AMA. Subsequently, C. Allen Payne, MD, was elected as Chairman and Robert J. Mason, MD, as Vice-Chairman.

During the past year the Judicial Commission has considered many important ethical questions raised by component societies, individual members and the public.

Guidelines have been developed for the notification to the State Board of Registration in Medicine in cases where members of the Michigan State Medical Society are suspended or expelled from membership for causes coming within the purview of the Judicial Commission.

The Commission has rendered an opinion on the ethics involved when a physician orders laboratory services through an organization and receives a fixed amount per patient for so doing. It was the Commission's decision that such a relationship is not ethical since the organization is in effect paying the doctor a finder's fee for its customers (patients). There is also some question about the legality of such a practice which is being investigated by multiple organizations concerned with this matter.

The Commission has considered at some length the problem of how to handle complaints by the public against physicians who are not members of MSMS. The Judicial Commission is without jurisdiction over such physicians but recognizes the obligation of organized medicine to act in the best interests of the public and of those doctors. The Commission would like to undertake, along with component medical societies, to mediate grievances and matters of ethics and professional conduct when requested by the persons in controversy with the non-member M.D., providing the latter agrees to accept the services of the Society in this respect and agrees to abide by its procedural rules. The Commission therefore presents the following recommendation:

RECOMMENDATION: That the House of Delegates adopt the following resolution:

Whereas, there are a considerable number of practicing doctors of medicine who are not members of their local county society or the Michigan State Medical Society, and

Whereas, there are occasional complaints from the laity against such non-members addressed to the local medical societies or to the Judicial Commission, and

Whereas, it would be imprudent and contrary to the obligations of organized medicine to the public, and contrary to good public relations, to dismiss such complaints on the basis of lack of jurisdiction over non-members, and

Whereas, the Judicial Commission wishes to work out a directive for equitable means of handling such complaints through the established structures within the Society when feasible and applicable, therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society look with approval upon efforts of the Judicial Commission to establish an equitable means of handling complaints (made by the laity) against doctors of medicine who are not members of the Society.

* * *

The Commission also rendered an opinion that a physician may not use the word "clinic" in connection with his practice if he is the only physician involved, even though he may have para-medical personnel associated with him.

The Commission is also considering ways in which its decisions can be appropriately disseminated to the entire membership, in the hope that we will all be better practitioners of the art and science of medicine.

The Commission is also compiling a list of previously rendered opinions to be available for the use of all members of the Society.

Other matters considered have been advertising of abortion clinics, physicians contracting with other physicians to care for patients in a hospital, MSMS claims review procedures, and physicians supplying copies of patient records to insurance companies.

The Commission has considered three appeals from decisions of component societies and has referred nearly 40 mediation, ethics or grievance matters to component medical societies for review.

REFERENCE COMMITTEE D, Thomas R. Berglund, MD, Chairman, recommended approval of the resolution of the Judicial Commission re how to handle complaints by the public against physicians who are not members of MSMS.

THE HOUSE adopted the report of the Reference Committee.

9. Report of the Michigan Delegation to the American Medical Association — Donald N. Sweeny, Jr., MD, Chairman

The 1972 Annual Meeting of the AMA House of Delegates June 18-23, 1972, San Francisco, California

The 1972 AMA House of Delegates was gaveled into order under apprehension of divisiveness—an apprehension prompted by the emotional conclusion in New Orleans by President Wesley Hall; the meeting was adjourned five days later with a feeling of unity—a mood engendered by the determination of all delegates to take a firmer grip on the leadership of organized medicine. There was a new look to the convention: forty new delegates were seated, and the new sections of students and house officers participated for the first time.

The majority of the business of the meeting concerned encroachments by government and other third parties on the practice of medicine and the establishment of bulwarks against those encroachments. Peer review and collective bargaining were discussed as major problems.

The House took a strong stand on drug abuse and fire arms. It approved the use of tax incentives to physicians in disadvantaged communities. Guidelines were adopted for compensating physicians' assistants, and the Board of Nuclear Medicine was given authority to issue certificates.

A major issue of the Convention was an effort to increase the input from the membership and to make the AMA more responsive to the wishes of practicing physicians—top priority was given to a discussion of membership communication. Therefore, the convention got under way a day early with the first national hearing before the AMA Council on Long Range Planning and Development to which the burden of assessing the future course of the organization has been assigned.

This hearing—which is focused on changes in the AMA Constitution and Bylaws, organizational structure, committee and Council responsibilities, and ways to improve the AMA —had a common thread running through much of the testimony given by more than 40 physicians. It was a quest for unity and the need to strengthen the AMA in the face of increasing government intrusion; the need to halt the growing fragmentation of organized medicine; and the need to open the association to more direct involvement of medical students and house officers.

Your Michigan Delegation participated in all deliberations, holding caucuses Saturday through Thursday at 7:30 a.m. and leading discussion not only in the House, but at all relevant Reference Committees. All elected delegates and alternates were active. Mr. Tryloff, Mr. Ambrose and Mr. Auer carried the heavy load of staff work. For purposes of discussing and not necessarily in order of importance, the actions of the House of Delegates can be divided as follows:

I. Peer Review

Threatened by pending legislation (Bennett Amendment to H.R.1) which would establish a federally controlled system of peer review and confronted with policies of Aetna Life and Casualty Company in setting its own prevailing fee with legal aid to patients whose physician's fee exceeded this profile, the House of Delegates

1) adopted a strong policy instructing the AMA to make it abundantly clear that management, labor, and third party carriers shall consult with representatives of organized medicine before determining usual, customary and reasonable fees; shall make use of peer review mechanisms as the primary method of resolving differences *prior* to litigation; shall insist that physicians have the privilege of entering into agreements with their patients regarding fees-for-services-rendered, third parties notwithstanding.

2) Although the House was in full accord that the evaluation of quality medical care is of necessity the responsibility of practicing physicians, the participation by public representatives was discussed and the problem was referred to the Council of Medical Service for refinement as regards the proper expenditure of public funds for health care.

3) The Bennett Amendment was strongly opposed and the policy that peer review be a local responsibility rather than a national effort was emphasized.

II. Government Health Programs

Relative to Medicare and Medicaid and other government health programs and legislation pending in this regard, the House of Delegates:

1) adopted a policy that approval by a hospital utilization review committee be considered as supporting evidence of the medical necessity for transfer of a hospital patient to an extended care facility.
2) requested the Bureau of Health Insurance of the SSA to require the Medicare carrier to send duplicate statements to the physician whenever payment is made to the patient.
3) endorsed a report on "Status of Certificate of Need Legislation in the U.S.," but stipulated that whenever and wherever such legislation is passed, it must provide that final authority rest with a board with adequate physician representation at the local level.
4) instructed the AMA to continue to protest and to take legal action if necessary against the discriminating acts of the Federal Price Board which limits fee increases for physicians in private practice to 2.5%, while permitting salary increases of 5.5% and higher to other workers.
5) strongly supported the creation of a separate federal Department of Health whose chief officer would be a physician of cabinet rank.
6) instructed the AMA to defeat state legislation designed to broaden the scope of optometry in such a way as to engage in the practice of medicine.
7) supported the concept that catastrophic health insurance as a national or local effort should not be free standing but be related to basic benefits.

III. Medical Manpower

Two reports worthy of careful review by all physicians from the Council of Health Manpower and Council of Medical Service (Education and Utilization of Allied Health Manpower and Manpower Programs) were received by the House of Delegates. Those reports indicated that substantial progress had been made in the area of medical manpower; the need for continued effort exists. Your Michigan delegation suggests that this Council receive these reports for its information and will have them distributed.

On the basis of these studies, the House authorized:

1) an expanded rule for nurses in providing health care.
2) approved guidelines for compensating physicians' assistants.
3) approved the use of pediatric, urologic, orthopedic and other specialty assistants trained under the aegis of their respective specialties.
4) ruled that a physicians' assistant is not functioning in that capacity when an employee of a hospital.
5) supported tax credits to medical practices in disadvantaged communities or in areas of critical physician need.
6) reaffirmed its opposition to proposals which would draft physicians for provision of civilian medical care.

IV. Medical Education

The major effort of the House was the approval of the establishment of a Liaison Committee on Graduate Medical Education in collaboration with the American Board of Medical Specialties, the American Association of Medical Colleges, the Council of Medical Specialty Societies, and the American Hospital Association.

On the other educational questions, the House acted as follows:

1) approved issuance of certification by the American Board of Nuclear Medicine, and conjoint board with subcertification on nuclear medicine by the American Board of Radiology and American Board of Pathology.
2) adopt essentials of approved programs for urologic physicians' assistants; respiratory therapy technicians; and medical assistants in pediatrics.
3) recommended that qualified osteopaths not be required to serve an AMA approved internship prior to accepting a residency if the specialty board in that field does not require an internship.
4) emphasized that in teaching hospitals, the patient's own physician must have overall responsibility for his patient's health and well-being, despite the role of the teaching physician, the resident, the intern, and the medical student.

V. Community Health

Based on a comprehensive report from the Board on the scientific findings, research, education on use and abuse and legal status of marijuana, the House adopted the following policy statement:

> "The AMA does not condone the production, sale, or use of marijuana. It does, however, recommend that the personal possession of insignificant amounts of the substance be considered at the most a misdemeanor with commensurate penalties applied. It also recommends its prohibition for public use and that a plea of marijuana intoxication shall not be a defense in any criminal proceeding."

VI. Membership

Although there were many actions directed at better communications with the membership, those reports indicated that there had been an improvement. It was announced that there had been a gain of 4,821 new members.

The issue of collective bargaining was a controversial issue; the Council of Medical Service was charged with studying the most effective way to allow collective bargaining and instituting class action on behalf of the medical profession. The Reference Committee in its report on this subject stated that "whatever a union or a guild can do lawfully, a medical society can also do lawfully." There were so many opinions expressed that referral to the proper council for a report in November was not only necessary but a relief.

The Board announced that the AMA Disability Insurance had been renegotiated with some substantial differences in coverage but without essential differences in premium or loss of life-time benefits.

A group term life insurance and excess major medical insurance program, each open to all AMA active members, interns, residents and executive staffs of medical societies was introduced.

The House urged all state and local societies to consider granting intern and resident membership with nominal dues.

VIII. Organization

The Constitution and Bylaws were amended as follows:

1) Active membership for medical students.
2) Submission of resolutions must be 30 days prior to meeting of the House.
3) Increased size of Board of Trustees (now 16) by making vice president a voting member.

Proposed Constitutional and Bylaws changes were:

The addition of one intern or resident member to each of the following Councils: Medical Education, Medical Services, Long Range Planning & Development.

A detailed financial report for 1971 was received and it was noted that although still operating at a deficit, it was estimated that the financial position of the AMA in 1972 will be in balance because of improved management, control, and economics.

The Delegates will be polled at the 1972 Clinical Session re term of members of the Board of Trustees, with the results of that poll being made available for definitive bylaw amendment.

VIII. Election

President-Elect—Russell B. Roth, MD, Erie, Pa.
Vice-President—Norman H. Gardner, MD, East Hampton, Conn.
Speaker of House—J. Frank Walker, MD, Atlanta, Ga.
Vice Speaker—Tom Nesbitt, MD, Nashville, Tenn.
Trustees—Doctors Jere Annis, Fla.; Burt L. Davis, Calif.; Robert B. Hunter, Wash.; Max H. Parrott, Ore.
Judicial Council—Burns A. Dobbins, Fla.
Councils—
  Constitution and Bylaws—Dan T. Cloud, Arizona
  Medical Education—Perry J. Culver, MD, and Vernon E. Wilson, MD
  Medical Service—Donald N. Sweeny, Jr., MD, Detroit; Hector W. Benoit, Missouri; (unexpired term, Doctor Dobens).

10. Report of Committee on Planning and Priorities — Stuart M. Gould, Jr., MD

In January, 1972, the current Planning and Priorities Committee was organized to include representation from the general membership, the House of Delegates, the Council of Medical Specialties, the Council of Medical Staffs, medical students, and so on.

Our original charge was a very broad one.

The Council told us that there was duplication of effort among the committees and attention needed to be paid to the priorities of the MSMS activities.

The Council was aware that functions and projects were continually being added but there was little, if any, review of or elimination of the existing activities. The Council wanted some planning and priority evaluation to be undertaken and therefore created a Planning and Priorities Committee with the structure that I have outlined.

In the previous year, the House of Delegates approved a recommendation that the attitudes of physicians be studied by an outside consultant group which would give additional direction to the Planning and Priorities Committee.

This report of the Alexander Grant Company (Phase II) was sent to members of the MSMS House of Delegates prior to the 1972 spring meeting.

A reference committee at that 1972 spring meeting of the MSMS House of Delegates discussed the Phase II Study and decided against a proposal that the House of Delegates appoint a committee to study the report. The reference committee report, which was approved by the delegates, in part said "the Reference Committee supports . . . the intent of this motion, but recognizes that this study would normally be conducted and reported by the Planning and Priorities Committee and that the make-up of this committee is a broad one with very adequate representation from the House of Delegates." The Committee then pitched in on its House of Delegates assignment to study the Phase II Report, and a number of meetings have been held to consider the recommendations about membership services, structure, etc.

Following are the current objectives of the Committee:

1. The Committee will study Phase II, the Physician Attitude Survey. This will give us insight into what the physicians believe should be the ranking MSMS priorities.
2. The Phase II Study will also bear review by the Committee since it comments on the restructuring of MSMS based on the company's interpretation of attitudes in the survey.
3. The Study also dealt with member benefits, and the physicians indicated those benefits they deemed the most important.
4. The 1971 House of Delegates also suggested that a member assistance fund should be studied by the Planning and Priorities Committee.
5. Our Committee will study the purpose and objectives of all MSMS committees. To this end, each existing MSMS committee has been asked to develop what it currently perceives as its purposes and objectives. The Planning and Priorities Committee will then review these and see if they correspond with the priorities as the Planning and Priorities Committee sees them.
6. The proper role of MSMS in continuing education has been assigned to our Committee for study. The physician attitude on this was touched upon in the Phase II Study.

Our Committee includes two members of the Wayne County committee named to study the Alexander Grant Report. We are pleased that they serve in this liaison role and that they are in effect members of our state-wide committee. As you read the committee list you will notice that the MSMS committee includes doctors from Wayne, Oakland, Washtenaw, Ingham, Genesee, Muskegon, Bay, St. Clair, Kent, Newaygo.

At our first meeting in February we recognized that there was a tremendous challenge before the committee and a great amount of work to be undertaken.

We decided that the work load of the Committee might divide into three areas: 1) committee structure, 2) membership services, and 3) responsibilities to the public.

The Planning and Priorities Committee has adopted recommendations of a preliminary nature regarding membership services which the Committee will weigh again later when it tries to put services and projects on a priority scale for the Council and the House.

All the ideas will have to be measured or balanced against the human and financial resources of the Society and decisions and recommendations that were made regarding the future programs of MSMS.

Top priority items will become part of the program, and low priority suggestions may have to be dropped.

These decisions will have to be made by The Council and the House of Delegates.

It was very difficult to get a handle on the study of the organizational structure of MSMS. We decided we couldn't deal with reorganization in the abstract, we could act more intelligently if we could react to proposals or alternatives to the organizational model proposed in the Grant study. It was agreed to instruct the staff to develop alternative exercises on organizational structure to give alternatives for the Committee to evaluate.

When the Committee reviewed the organizational exercises, the members were impressed with the fact that there were an almost infinite number of combinations of organizational ideas. The Committee agreed that there should not be change simply for change's sake. Committee members also felt there were probably some very basic points that needed to be given serious consideration and other organizational changes that needed little consideration.

The last part of the most recent meeting was interesting to me, and all felt it was very worthwhile. We discussed three organizational exercises and then we went around the room several times to draw out comments and questions from the committee members. There was no attempt to measure the value of any of the suggestions, but the comments were recorded for review at the next meeting in November.

The Committee anticipates that it cannot be ready with a final report probably until the fall of 1973 but it is possible that the March meeting of the House of Delegates in 1973 could or should be the target date.

The Committee is going to follow the instructions of the spring House of Delegates to take these ideas for change to the membership, hospital staffs, non-members, county medical societies, the AMA, the Council of Medical Specialties, etc. We believe that we should consider these presentations to these audiences as "hearings" where we will throw out ideas and serve as a listening post for the reactions of the group.

This generally would follow the pattern of the AMA Committee on Long Range Planning, which holds hearings around the country and is doing so at this fall meeting of the MSMS House of Delegates. We do not anticipate that our full committee need be present at each one of these hearings, however.

In November, the Planning and Priorities Committee will meet again to review additional exercises and begin planning for its hearings. I must report that the Committee is a diverse group of people who have accepted this challenge with a great deal of interest and fervor. Each is really dedicated to improving MSMS where improvement seems desirable. There is no thought in my opinion on the part of any member of the Committee to make any, let us say, drastic move. We are all trying to solve the problems that are perceived by us individually within our component societies that may reflect upon the operation of the State Medical Society and as indicated by the Alexander Grant Physician Attitude Survey and our proposed hearings.

One of the things that we hope will come out of our deliberations will be suggestions for the proper role of MSMS in society and in organized medicine, and perhaps some suggestions about the functions and responsibilities of component societies also. To the extent that there is overlap of concern and responsibilities and duplication of effort, probably these ought to be reviewed and eliminated where possible. In the coming years and months, MSMS will need all of our resources and our energies to be directed toward the principal problems facing physicians.

I do not believe personally that we can afford to do those things which contribute little to our health and welfare.

11. Report of the Woman's Auxiliary — Mrs. Marian Schoff, President

(The following report of the President was presented in written form.)

The emphasis in Woman's Auxiliary in this 1971-72 year has stressed the need to adapt; not only to our changing world, but, as physicians' wives, to unite and guide these changes as they relate to our lives. It is the hope that young women coming into our organization will find meaningful challenges, while stimulating and attracting members who have become "drop-outs" to rejoin.

I continue to be appalled at the number of Medical Society members (our own husbands, yet!) who do not realize that we are YOUR auxiliary . . . your right arm to the county, state and national societies. We are *not* to be confused with local hospital auxiliaries, even though many of our Medical Society Auxiliary members have sufficient community interests to choose to be active in hospital auxiliaries, too. With community service in the health field one of our major areas of concern, we applaud all who channel their energies in these directions . . . and to the related projects such as "meals-on-wheels," cancer detection clinics, blood banks, drug education, friendly visitors to the aged, mental health volunteer services, crisis phones, preparing and mailing Easter Seals, in addition to the AMA-ERF health career recruitment and scholarships, International Health and Legislative activities that comprise the Woman's Auxiliary's main areas of activity.

In the Legislative area, for instance, the importance of being INFORMED has taken top priority. To facilitate this, our 5th annual Legislative Day saw 85 auxiliary members from around the state joining 55 legislators and 15 staff personnel for a day of workshops, discussions and lunch. Dr. J. Coury and Dr. L. Zako addressed the group on issues pertinent to the State Medical Society.

$38,244.23 was collected for AMA-ERF. For recognition, Macomb County received an award from the National Society Auxiliary for having the largest per capita donation; the State of Michigan received an award as one of the highest per capita donors ($10). Meanwhile, contributions from individual physicians were down by $9,500. It would seem that you do not realize that a contribution to your medical school *via* AMA-ERF aids *both.*

In addition to AMA-ERF, over $28,000 in direct scholarships and loans to health career students sponsored by local groups were given.

While our accomplishments have been many, they remain modest in relation to what could be done if YOU would *remember us, involve us,* and most of all, encourage your wives to join. Our prime purpose for existence is to help you and the image that medicine projects in your community. (In addition, we have a lot of fun!) We are not a fluffy bunch of bubble-headed joiners who want to see their picture in the papers . . . we are do-ers! "Do-ing" could not be facilitated with ease however, were it not for the invaluable assistance of Jackie Van Deventer, Mr. Tryloff's patient ear, the many staff people in the MSMS office and the financial assistance from you. These services are greatly appreciated, and the gift of time by these people "greases the wheels" of our tasks.

It has been my very great pleasure and privilege to have served as President of the Woman's Auxiliary to the Michigan State Medical Society in 1971-72. I'm turning over my pin and gavel, but not my interest in better health via the free enterprise system of medicine. I shall remain involved, actively!

12. Report of the American Association of Medical Assistants, State of Michigan — Miss Margaret Broadwell, President

(The following report of the President was presented in written form.)

The American Association of Medical Assistants is a professional association dedicated to the education and self-improvement of medical assistants, both on the job and through organizational activities. All assistants, secretaries, bookkeepers, nurses, technicians and receptionists may join AAMA.

AAMA is a non-profit organization. It is not nor shall it ever become a trade union or collective bargaining agency.

At the AMA House of Delegates in 1962 and 1967, resolutions urging support of AAMA and its activities were adopted. The members of AAMA, State of Michigan, with a membership to date of 860, deeply appreciate the fine support of the doctors of Michigan, Mr. Warren Tryloff, MSMS Director, and particularly the fine coordinating service of Mrs. Jackie Van Deventer.

The annual convention was held April 27-29, 1972, in Kalamazoo. Action of the House of Delegates included a resolution conferring an honorary membership of AAMA, State of Michigan, on Betty Lou Willey, CMA, a former state president and speaker of the House for AAMA for many years. Mrs. Willey is also a candidate for vice-president of AAMA this year.

A reception honoring Doctor and Mrs. Glenn Millard at the state convention marked the end of a long and dedicated service by Dr. Millard, as Chairman of the Advisory Committee to AAMA, State of Michigan.

Within the environs of Schuss Mountain, Mancelona, another successful Summer Seminar was held in July 1972, with Robert Haakenson, Ph.D., and Paul T. Lahti, M.D., Advisor, as speakers. In keeping with our policies on in-service training and educational content of the meetings, seminars and conventions are scheduled for September 16-17, 1972, at the Hospitality Inn, Lansing; October 17-21, 1972, National Convention, Phoenix, Arizona; January 20-21, 1973, at the Hayes Hotel in Jackson; and the Annual State Convention April 26-29, 1973, at the Dearborn Inn, Dearborn.

State advisors to the Medical Assistants appointed by The Council of MSMS for the year beginning May 1, 1972 are:

Barry H. Alford, M.D., Chairman	1 year term
Vernon V. Bass, M.D.	1 year term
Paul T. Lahti, M.D.	1 year term
John J. Coury, M.D.	2 year term
Albert D. Engstrom, M.D.	2 year term
Laszlo Kovacsi, M.D.	2 year term

The American Association of Medical Assistants, State of Michigan, recognizing that the well-trained assistant can relieve the physician from non-medical pressures of his office, is striving to provide educational material to improve the performance of its members, and in preparation for certification. The AAMA has established a certifying board along the same lines as medical specialty boards. Passage of various sections makes the candidate eligible for certification as a Certified Medical Assistant in the areas of administrative, clinical or dual. To date Michigan has 18 CMAs.

REPORT OF THE COUNCIL

13. Remarks of The Council Chairman — Brooker L. Masters, MD

I hope you have read in its entirety the Annual Report of The Council for there has been an unprecedented amount of activity on the part of the officers and the staff.

We have improved our communications both with the profession and the public.

We have achieved some major objectives in legislation.

We have substantially increased our economic information.

We have a new staff effort in recruiting and maintaining membership.

We have enlarged services to our members so that they will receive more benefits from their membership.

The Planning and Priorities Committee has made considerable progress and will report to you separately.

We have weathered the financial trials of 1972, will end the year in a good position and have a preliminary budget for 1973 that is in balance.

The Annual Report contains information through the September 13 meeting of The Council.

The major problem facing medicine this year has been the state take-over of the Medicaid program. Your leadership has worked long and hard on this critical problem. Negotiations are continuing. This House of Delegates will be making some important decisions in the next two days and undoubtedly, there will be public relations ramifications resulting from your decisions.

Already there have been scattered newspaper accounts that some doctors won't care for Medicaid patients. We must find ways to explain our positions. We must develop methods to fulfill our professional responsibility to provide medical care.

You delegates must give The Council some guidelines in policy, particularly on the question of uniform fee level versus the usual and customary payment. In March, The Council reminded the House that there were conflicting resolutions adopted by this House in 1971 which needed to be resolved. These questions were not resolved.

You delegates must be specific regarding the items that you wish to be negotiated in the new Medicaid program. Perhaps more importantly, you must clarify the basic principles which you want incorporated in any third party program.

The Council has been praised and criticized for its leadership in the Medicaid program.

Praised for its distribution of information to the entire membership.

Praised for its achievements in negotiating with the State Department of Social Services.

Criticized because it did not make a specific recommendation to sign or not sign the provider agreement.

The Council today received a report from the Ad Hoc Negotiating Committee which met with representatives of the Department of Social Services last Thursday, September 21. The Council on September 13 had said that it would be willing to recommend participation of our membership in the Medicaid program, providing three points were negotiated.

1. The Provider invoice number 18 be not a requirement for payment.
2. Provider invoice number 34 be not a requirement for payment.
3. That the one-time provider agreement be abandoned in favor of a per case agreement mechanism.

As a result of this meeting, Items 1 and 2 were successfully negotiated, but Item 3 regarding per case agreement was not completed. The Department simply agreed to restudy the matter.

Based on the foregoing report, The Council today adopted a recommendation for the House, as follows:

RECOMMENDATION: That the House of Delegates approve The Council's decision to advise the membership that further signing of provider agreements be held in abeyance until negotiation on the per case agreement mechanism is completed. The Council hopes the negotiations will be concluded soon and when they are, The Council will make an additional recommendation to the membership, depending on the outcome of negotiations. (For House action on this recommendation, see Res. 72A-10.)

In addition at The Council meeting today, The Council heard a progress report in the development of the Bylaws of the peer review organization, Medical Programs, Inc. As The Council already has reported to this House, the osteopathic association has decided not to participate in Medical Programs, Inc. Therefore, The Council instructed a committee to eliminate from the Bylaws all references to osteopaths and the osteopathic association. The Bylaws are now ready for implementation when The Council deems necessary.

At my last meeing of The Council at noon today, I took the Chairman's privilege to make some personal remarks to The Council about some forthcoming challenges. I offered some personal observations regarding The Council's activities in the future. These are not recommendations to this House.

My suggestions to The Council today were in several different areas. Let me just highlight them for you.

Concern #1: Our officers and staff should get to more county meetings. In order to make it possible for Doctor Coury and others to visit component societies and to represent MSMS at various meetings, I urged The Council today to consider more use of chartered air service. You know that service as an officer cuts into office practice time. An occasional chartered flight can make it possible for Doctor Coury, for example, to practice all day, fly to the county medical society meeting at Cadillac, Benton Harbor or Marquette, and still fly back home by midnight.

Concern #2: The Council in August compiled a list of the many MSMS members who serve as representatives to statewide agencies and organizations. I recommend that these representatives be invited to give progress reports to The Council and to ask for guidance and advice. Our efforts must be coordinated.

Concern #3: There has been much new activity this year in the field of membership and recruitment. I challenged The Council to expand these new staff efforts and to coordinate membership retention and recruitment with the component societies.

Concern #4: In our travels around the state, some members have been critical that The Council did not inform them earlier about the state take-over of Medicaid. The matter has been in our minutes and has been handled by committees since July, 1970, but I feel that you delegates and the counties want us to alert you more about upcoming issues and concerns. So today I urged The Council to immediately get new information about HMO's, about possible changes in Medicare, about health cost studies soon to come from the Governor's office and about rumors I hear about major changes planned by Michigan Blue Shield.

My closing comments to The Council and to you today about *Concern #5* will focus on our MSMS goals and purposes. Many members have asked me what The Council or MSMS is planning to do about this problem or that issue. I urged The Council to select a small task force of leaders to work with the staff to identify problems, to explore solutions and to develop alternatives that would enable The Council to recommend to the House of Delegates some clear-cut, easily understood objectives for MSMS. The House, in its short sessions, really does not have the time to do this. The new Planning and Priorities Committee is considering overall priorities and long-range goals, but doesn't have the capacity to determine short-term objectives. Only by identifying short-range and long-range goals can MSMS use the volunteer time of our many members and leaders, and the talents and treasury of MSMS to accomplish visible, impressive results. I am sure you concerned, dedicated delegates agree with me that MSMS must be relevant and action-oriented.

Thank you for letting me share these five ongoing concerns with you.

This is my last function as a member of The Council, for I have completed my third term as Councilor of the Eleventh District. I have enjoyed this service and hope that I have made a lasting contribution to MSMS in the practice of medicine. It has been one of the most rewarding experiences of my life to have served as Chairman of The Council for the past year. The members of The Council and the staff have given outstanding support to The Council's efforts and I praise them in the same breath that I report how stimulated I have been by the experience.

REFERENCE COMMITTEE D recommended that appropriate action be taken on the concerns of Council Chairman Masters.

THE HOUSE adopted the report of the Committee.

14. Report of Council Activities

PART I

These pages report the highlights of The Council's work during 1971-72 in the usual ongoing areas of MSMS service, such as legislation, communications and postgraduate medical education.

In Part I, The Council comments on some general activities. Detailed reports are unnecessary since minutes of The Council's meetings are mailed regularly to Delegates and component medical society leaders, and abstracts of Council actions appear regularly in *Michigan Medicine*. Delegates or county officers with questions about items that follow are urged to contact their MSMS Councilor or the MSMS staff.

MSMS Membership

Membership in MSMS on December 31, 1971 stood at 8,101—a record figure. The gain over the previous year was modest, but many other professional societies are experiencing declining membership. The June 1972 membership is about 100 members higher than the June 1971 figure. Following are the MSMS membership figures:

Year	*June 30*	*December 31*
1935	3410	3543
1945	4425	4686
1955	5503	6109
1960	6660	6715
1965	7247	7563
1970	7643	8062
1971	7645	8101
1972	7741	———

Finances

Expenses for 1972 are in line with the estimates in the Budget. There have been four authorized increases in the budget: $1,000 for President's Project-Position Paper on Scope of Benefits in Governmental Health Care Package; $1,500 for the AMA Delegation Travel and Expense; $7,400 for Council Meeting Expenses; and $5,000 for Information on Medicaid to Membership.

Annual Session Exhibit Sales will be approximately $13,000 for 1972, or $2,000 below the budget amount.

Advertising income from *Michigan Medicine* considerably below the budgeted amount. For the year the amount should be around $67,000 or $13,000 below the 1972 estimate. However, there will be a corresponding decrease in the printing expense of the Journal.

Dues income and other income will reach the 1972 estimates.

Following is a balance sheet for the eight-month period ending July 31, 1971. It shows the status of our assets and liabilities and the resulting Members' Equity. The investment funds will be described in detail in the Treasurer's Report.

BALANCE SHEET
July 31, 1972

ASSETS		
CURRENT ASSETS		
Cash	$ 5,766 Cr	
Accounts Receivable	8,037	
Pension Trust & Due from Employees	9,777	$ 12,048
*INVESTMENTS IN SHORT TERM SECURITIES		465,000
Transferred to Reserve Fund (1972)		100,000
INVESTMENTS IN FUNDS		
Capital Reserve Fund		338,367
Capital Protection Fund		372,830
FIXED ASSETS		
Building	606,235	
Furn. & Equipment	111,354	
Less: Accumulated Depreciation	171,050	546,539
Land		75,971
OTHER ASSETS		
Prepaid Expense		830
TOTAL ASSETS		$1,911,585
LIABILITIES AND MEMBER EQUITIES		
CURRENT LIABILITIES		
Accounts Payable (Est.)		$ 15,000
Property & Other Taxes Payable		5,800
LONG TERM LIABILITY		
Mortgage Payable		606,656
Long Term Liability to Retired Exec. Dir.		18,200
(Funded as part of short term securities)		
MEMBERS EQUITY		
Members' Equity (Net Worth)		1,265,929
		$1,911,585

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*$100,000 Funds Transferred to Reserve Fund 1972
$465,000 Short Term Investments (Operational Fund)

Medicaid

There have been many activities in the area of Medicaid on the part of The Council during the past few weeks and months. Periodic progress reports were provided to the membership. A letter to all members of MSMS dated September 1 was entitled "Council Advice re Medicaid Provider Agreement." (See Addendum.)

Since that time, at our September 13 meeting, The Council instructed the Negotiating Committee to confer with state officials on three matters: Items 18 and 34 of the Invoice Form re duplicate payments from Medicare and Medicaid and signing Provider Agreements for each individual case rather than the blanket Provider Agreement now required.

Committee Activity

Until the Planning and Priorities Committee makes its final recommendations regarding committees and their structure, The Council is again notifying the House that it is not making any recommendations for permanent change in the names and numbers of committees, but simply requests that the House permit The Council to continue on an experimental basis with the regrouping of some committees until after the final report of the Planning and Priorities Committee in 1973.

Meanwhile, considerable activity took place with 33 committees holding more than 95 meetings.

Planning and Priorities Progress Report

The Planning and Priorities Committee will make a verbal report to this House of Delegates which will contain no recommendations, but simply inform the House of the considerable progress that the Committee is making in carrying out its task as instructed by this House of Delegates.

The Committee gave a progress report to The Council August 5 and it was received with commendation.

You will be interested to know that simultaneously, and unknown one to the other, there are some seven state medical associations that are going through similar studies of their own structure and the purposes of their committees and membership services, seeking to find ways to improve the relations with their membership and to make the organization more meaningful to both society and the members.

Chairman Stuart Gould has done a fine piece of work, and I'm sure you will be impressed with his report and the systematic way they are getting input from the officers, House of Delegates, Council, AMA and the general membership.

Liaison with Speciality Organizations

The Council has been relating to the newly formed independent Council of Medical Specialities, whose moderator is Glenn Moore, MD, of Flint, with past president Harold Hiscock as permanent advisor.

The Council of Medical Specialities has met periodically in the MSMS headquarters, studied problems of concern to its membership, and received reports of specific interest from the MSMS officers and staff. This organization provides a firm medium of communication between the speciality groups and MSMS.

Doctor Moore is welcome to attend any meeting of The Council and did attend the midsummer meeting of The Council as a representative of the speciality organizations.

Liaison with Michigan Medical Service and Michigan Hospital Service

The Council realizes that there is a need for communication between these two organizations and the MSMS Council has stipulated staff-to-staff liaison communication line and is working with the two Blues regarding communications at the leadership level. Also, The Council will continue to study the problem of receiving reports from the MD members of both of the Boards so that The Council gets pertinent information and can be aware of developments and plans of the two organizations.

Peer Review & Foundations

The MSMS peer review structure, which is composed of (1) county society committees dealing with utilization or fee complaints, (2) regional medical advisory committees within each councilor district and (3) the MSMS Committee on Utilization and Health Insurance Problems, has been active in dealing with utilization and fee problems brought to it by both Michigan Blue Shield and Commercial health insurance companies. The MSMS Utilization Committees now have several matters on appeal.

The House of Delegates at its Spring meeting, March 20-21, 1972, considered Draft #7 of the Articles of Incorporation and Bylaws for the proposed MSMS Foundation. The House approved Draft #8 as amended by Reference Committee "A", and directed Michigan Medical Services, Inc., be established at the state level for peer review to be implemented at the direction of The Council.

On May 6, 1972, The Michigan Association of Osteopathic Physicians and Surgeons Board of Trustees voted to rescind its previous action of pursuing the formation of a foundation with MSMS, and adopted a motion to pursue the establishment of an osteopathic foundation.

The Council has since established the Committee on Medical Foundation to revise the Foundation Bylaws as necessitated by the action of MAOP & S. Draft #8 of the New Bylaws will be reviewed by The Council at its meeting of September 13, 1972 and October 1.

Member Services

Car Leasing Program: A new car leasing program for MSMS members has been approved by The Council for membership. McCullough Leasing, Inc., will operate the program at very special rates. Complete details were mailed to all MSMS members on August 8, 1972.

Car Rental Discount: The Council authorized MSMS participation in an agreement with a car rental corporation that would extend a 20% discount to MSMS members who rent cars in the continental United States, Alaska, Hawaii and Canada. Cars rented elsewhere in the world would enjoy a 10% discount. Final negotiations are under way and when completed, details will be announced to MSMS members.

New Disability Program: The Council approved recommendations from the Committee on Professional Insurance Plans to broaden the MSMS disability program by offering interns and residents, under age 34, who become associate members of MSMS, disability insurance at a very low cost. Specifically, this insurance would offer $325 monthly indemnity on a Lifetime Accident—Five-Year Sickness Plan with benefits commencing first day for accident and sixteenth day for sickness at an annual premium of $10. This new offering will assist in our membership campaigns to enroll younger physicians and will improve the overall age distribution of those participating in the MSMS plan.

Blue Cross/Blue Shield Coverage for Widows of MSMS Members: The Council approved the recommendation of the Insurance Committee that widows of MSMS members be allowed to continue in the MSMS Blue Cross/Blue Shield 94000 Group. Details are now being worked out with Blue Cross/Blue Shield.

Both the Committee and The Council are aware that the inclusion of widows might affect the experience rating of the 94000 Group and result in higher premiums, but they feel that this consideration is outweighed by the obligation that MSMS has to make adequate health insurance available to widows of deceased members.

Blue Cross/Blue Shield Low Cost Option Program: At the request of MSMS, Blue Cross/Blue Shield are now developing new optional coverages containing deductibles and co-insurance features as available alternatives to the existing MVF programs. The Insurance Committee has these new programs under study.

Basic Professional Liability Insurance: In November 1971, The Council authorized Johnson and Higgins to investigate, on an exclusive basis, a possible professional liability insurance program for consideration by MSMS. The J. & H. Los Angeles office had arranged a successful professional liability insurance program for physicians in seven counties in southern California. J. & H. reported to The Council on August 4, 1972 that although two large carriers were interested, neither would offer rates competitive with the Medical Protective Company. J. & H. requested permission to continue their study on a non-exclusive basis and this authority has been granted.

Other Programs: The Council, Finance Committee and staff are working on the development of additional new benefits in the areas of discount purchasing and workmen's compensation.

Membership Activities

MSMS has developed some new support activities for component medical societies in their membership recruitment work and has started some new recruitment procedures and programs.

The Council, upon the recommendation of Council Chairman Masters to the House, appointed in April, 1972 a new ad hoc advisory committee for expanded MSMS membership activities.

The Committee authorized the following new activities, which are being carried out:

1. Send letters to graduates of the three Michigan medical schools congratulating them and suggesting affiliation as interns at all three levels, county, state and national.
2. Send letters to all other Michigan interns about advantages of membership at all three levels.
3. Send similar letters to residents.

In addition, the State Department of Registration in Medicine is now regularly providing to MSMS the names and addresses of newly-licensed doctors for contact by component societies and MSMS.

MSMS now mails Medigram (not the regular journals) to all interns, residents and non-members in a new effort to prove that MSMS is working hard for the doctors and the patients.

MSMS is writing to each doctor who has dropped his AMA membership, urging reconsideration.

MSMS is writing to those who are delinquent in paying component society and MSMS dues.

President-elect John J. Coury, MD, held three informal discussions this spring and summer in Kalamazoo, Lansing and Mt. Clemens with doctors under 45. Doctor Coury plans to visit this fall with hospital staffs in another new effort to improve communications and to sell all three levels of membership.

A pilot orientation meeting for new MSMS members is scheduled for November.

An ombudsman is still under consideration.

Medical Economics

The Bureau of Economic Information has continued to add to its expanding data and information bank through its investigation into the socio-economics of medicine in Michigan and the United States.

Among the Bureau's many projects, several major endeavors stand out: the survey on physician overhead costs, investigations of different modalities on the deliverance of health care, research on the Medicaid Program, and its work on the Price Commission's rulings.

The Overhead Cost Survey and Physician Fee Survey findings have been of major importance. The results were extensively utilized in a meeting between the Committee on Medical Socio-Economics and representatives from Michigan Blue Shield. The purpose of the meeting was to review the current reimbursement mechanism for physician services. The Bureau played a role in the development of data for the Medical Socio-Economic Committee. Three areas of concern were prominent after the meeting: 1) entry level profiles of a new doctor, 2) immediate area adjacent problem, and 3) limitations on requested fee increases made by doctors who request increases on an infrequent basis. Blue Shield officials are studying these areas and have promised possible solutions to these situations.

The Bureau acquainted itself with the rulings and laws established by the Price Commission re physician fees. It supplied the membership with an interpretation of the regulations, and explained in *Michigan Medicine* how the guidelines actually functioned. Support data was supplied to the officers of the Society who formally protested the unfair guidelines.

Much of staff work for the discussion of the Medicaid Program was from the Bureau. The Bureau's function was to analyze the physician reimbursement system and suggest improvements in the mechanics of the new program.

Besides acting as a source of information for committees and other staff members, the Bureau is exploring the economics of the various emerging forms of delivering health care.

One such form is the Metro Health Plan, located near Detroit. An in-depth study was conducted and will be synopsized in *Michigan Medicine.*

The MSMS Economic Consultant, along with other staff members, critiqued a report from the Governor's Office of Comprehensive Health Planning regarding Health Care Costs in Michigan. Meetings were held with the authors of the document and MSMS concerns were delineated. Many changes that more fairly explained the real facts were suggested. Constant review and suggestions are going to be made on each draft of the Governor's Report, with the hope that the Office of Comprehensive Health Planning will incorporate our suggestions.

Legislation

After 35 years as a statute, Michigan's Basic Science law was repealed this year through a bipartisan legislative thrust closely related to MSMS's long effort to over-ride the restrictive effects of the law. The repeal was signed by Gov. Milliken June 16 before a gathering of Michigan physicians and lawmakers who placed the repealer as a top priority for the 1972 legislative session.

The Basic Science repeal headed a list of goals authorized by The Council. Others included revision of the Medical Practice Act, which was originally enacted in 1898 and often amended in the intervening 74 years. The proposal is designed to liberalize the requirements for licensure and give some discretion to the licensing board in dealing with individual cases. A limited license, a "sick doctor's act," access to the Board of Registration through a lay-dominated advisory committee, and adjustments in educational requirements are embodied in the revision. The bill was developed through the cooperation of The Council and the Board of Registration.

Attempts to establish the worker category of "Physician's Assistant" attracted some notice among legislators but fell short of achievement. The Council authorized a position that, if and when Physician's Assistants are recognized by Michigan law, they should be under the direct authority and regulation of the Board of Registration in Medicine.

Legislative efforts also were directed by MSMS to several appropriations matters. Strong Council reaction to the Governor's proposal that Medicaid billings, paid within 30 days, be discounted by three per cent, won support among the Legislature and ultimately by the Governor himself, who informed The Council in May that he had withdrawn the recommendation.

MSMS monitored and provided information to legislators in the development of the Medicaid portion of the Department of Social Services appropriations bill, as well as advising on appropriations for medical schools in the state. Subsequent legislation provided $72 million for the physician line item in Medicaid, up $8 million from the fiscal 1971-72 year, and the Higher Education appropriations bill directed increases in all medical schools.

MSMS provided information upon which the Legislature enacted protection from subpoena for physicians serving on hospital review committees. Another medically important measure requires physicians who diagnose lead poisoning in patients to report same to the County or State Health Department.

A major effort to develop acceptable malpractice legislation saw the appointment and start of work of a Special Joint Legislative Committee on Medical and Hospital Malpractice. The committee in turn established its own citizen advisory committee, on which MSMS has two members. No effort was made to develop bills for introduction in 1972, but the committee expects to report to the full Legislature with recommendations in 1973.

A second legislative study committee, on the need to increase family practice physicians, did not function because the full committee has never been appointed by the Legislature.

Emphasis continued on legislative liaison. In addition to daily contacts with legislators on specific matters, MSMS delegations met twice with the Governor to consult on medical concerns, and once each with the Senate Appropriations Committee, the House State Affairs Committee, the Subcommittee on Social Services of the House Appropriations Committee and the Senate Committee on State Affairs.

Congressional Contacts. Delegations from MSMS made two special trips to Washington on congressional matters. In March, in conjunction with Michigan Doctors' Political Action Committee, the Chairman of The Council and two Council delegates to MDPAC entertained Michigan's Congressional delegation in Washington, and later participated in the annual AMPAC workshop. In August, with the Wolverine State Medical Society, MSMS conferred with AMA staff and with congressmen on HMO and National Health Insurance legislation.

Volunteer Lobbying Program. The "Doctor-of-the-Week" program continues to be a popular and effective program in the State Capitol. From February through June, 18 Michigan physicians from widely varied backgrounds participated in the weekly volunteer lobbying program. This year physicians brought their wives with them to Lansing, this added impact to the conversations with legislators.

"Doctors-of-the-Week" in 1972 were from Cass, Delta, Ingham, Kalamazoo, Kent, Lapeer, Livingston, Macomb, Mason, Monroe, Oakland, Oceana, Washtenaw and Wayne counties.

Communications—Professional, Public

Michigan Medicine. The MSMS journal continues to serve as a medium for informing members about the concerns, activities and accomplishments of MSMS and for the presentation of scientific papers. Beginning in January, *Michigan Medicine* has carried four pages of "Sound Off" comments to encourage more discussion of medical issues. Multiple uses are made of journal articles, etc., and a pull-out poster for the doctor's office was printed in July with the message, "Thank You for Not Smoking" as part of The Council-approved stop-smoking effort. Journal advertising has dropped off this spring and summer so the issues necessarily have been smaller.

Liaison with Component Societies. Work in this area was increased this year under the direction of The Council. MSMS officers and councilors have visited many component societies and each senior staff member visited one or more components each month. In a new activity, the component societies of Eaton, Shiawassee and Livingston accepted MSMS invitations to hold one of their membership meetings at the MSMS headquarters in order to view the facilities and meet the senior staff. This project will be expanded in 1972. A workshop was held in November 1971 for presidents-elect of component societies and a workshop was held later for the county society secretaries, editors and executives.

Liaison with Other Organizations. Once again, MSMS leaders, committees and staff members worked effectively with such organizations as the state Woman's Auxiliary to MSMS, the State Medical Assistants' Society, the three SAMA chapters, Michigan Hospital Association and many others. There was a decided increase in the cooperative efforts of MSMS was the statewide Wolverine Medical Association and the Detroit Medical Society with good results in the areas of legislation, communications, etc.

Communications with the Public. The annual report of the MSMS Committee on Public Relations describes special and ongoing efforts of MSMS—The Council, officers, committees, et al, to reach the public through the press, radio, television, publications, speaker's platforms, etc.

Continuing Medical Education

MSMS continued to provide many postgraduate medical educational opportunities for members; with interns, residents, and medical students invited to participate.

1971 Annual Scientific Session. For the first time in several years, the Annual Session was held in Grand Rapids, where attendance always is less than in Detroit. There was fine cooperation from the many MSMS Sections. The exhibits were moved from the basement into the main first-floor arena with good results.

1971 Fall Series. In the fall of 1971, the MSMS Committee on Postgraduate Medical Education sent speakers into 18 communities in the lower and upper peninsulas, with the cooperation of the three medical schools and the Michigan Department of Public Health. The usual 1972 spring series was not presented this year because the budget allocation had been reduced while the entire continuing medical education thrust of MSMS is being reviewed.

Maternal and Perinatal Health Conference. The 1972 spring conference, held again in Lansing, drew more participants than ever before. This 11th annual conference featured a special program for the Nurses' Association of the American College of Obstetrics and Gynecology.

The usual two-day conference at the Michigan State University Gull Lake Conference Center was held again this year for members and guests of the MSMS Committee on Maternal and Perinatal Health.

Conference on Medical Aspects of High School Sports. This seventh annual conference for team physicians, coaches and trainers was held at the University of Michigan Towsley Center under the leadership of the MSMS Committee on the Medical Aspects of Organized Athletics.

Michigan Workshop on Alcoholism and Drug Abuse. The MSMS Committee on Alcohol and Drug Dependency and the Governor's Office of Drug Abuse and Alcoholism are joining to sponsor a statewide workshop at the MSU Kellogg Center Sept. 19-20 for physicians and the public.

PART II

MATTERS REFERRED TO THE COUNCIL BY THE 1971 HOUSE OF DELEGATES

Substitute for Resolutions 6 and 20—Establishment of a Uniform Fee Schedule for Medicaid Payment. MSMS has followed the development of House Bill 5305 and House Bill 5837, both of which would establish a uniform fee schedule for Medicaid payments. MSMS has advocated the uniform fee schedule based upon the 1971 Relative Value Scale with a 5-digit CPT and with an annual review of payments. The change from Blue Shield to the Department of Social Services of intermediary functions over Medicaid has created considerable dynamics, but no resolution derived.

Resolution 8—Drug Abuse. This resolution called for MSMS to urge a voluntary statewide moratorium by members on the prescription of amphetamines for diet control. A by-line article by Richard C. Bates, MD, Chairman, MSMS Committee on Alcohol and Drug Dependency, appeared in the March 1972 issue of *Michigan Medicine* and a November 9, 1971, MSMS news release appeared in many newspapers.

Resolution 12—Relation of MSMS with Michigan Congressmen. MSMS has increased its contact with Michigan Congressmen, through MDPAC and the Department of Government Relations. Three trips to Washington by physicians and staff have tended to develop liaison with the Congressmen, and numerous telegraph and mail contacts have been made. On March 9, 1972, 12 members of the House of Representatives from Michigan, and Senator Hart attended a reception sponsored by MDPAC and partly supported by MSMS; on August 1 and 2 Michigan doctors met with Congressman Esch, Mr. Woolner from Senator Hart's office and Senator Griffin. Continuing MSMS-to-Congress contact is anticipated.

Resolution 13—Summary of Medical Laws. The feasibility of a summary of medical laws has been considered by Legal Counsel, who finds it extensive and expensive. Further, the addition to medical laws at both the State and Federal level would make such compilation obsolete within a year's time. No further action has been taken on this resolution.

Resolution 14—Homicide Prevention—Gun Control. Copies of Resolution 14 were circulated among the Executives of Michigan, the Legislature, and members of Congress. However, neither at the state or federal level was effective gun control legislation enacted.

Resolution 16—No Fault Malpractice Insurance. Various means to relieve the malpractice insurance puzzle are under consideration by the Legislature, a special committee of the Legislature and its advisory committee, and through a cooperative series of meetings between medical and osteopathic physicians. A concept of no-fault malpractice insurance has been introduced to all of these groups. No definitive program for malpractice insurance really has developed.

Resolution 17—Computer Committee. An MSMS Committee on Computers has been appointed, as directed by this resolution, with Robert M. Stow, MD, of Lansing, as its Chairman.

Substitute for Resolutions 19, 21 and 27—Institution of Legal Action Against the State of Michigan. This resolution calls upon MSMS to reaffirm its commitment to require the fiscal intermediary to pay for services at usual, customary and reasonable rates. This resolution was considered in context with Resolution 6 calling for a uniform fee schedule. Extensive conversation with State officials assumed the fiscal intermediary functions from Blue Shield. Some adjustments in rates have been verbally promised by the Department.

Resolution 24—Revision of Pharmacy Rules. This resolution recommended amendment of Michigan Board of Pharmacy rules to permit registered nurses to dispense medications, ordered by a qualified physician, from hospital pharmacy stock bottles in the absence of a registered pharmacist. The Council forwarded the resolution to the Liaison Committee with the Michigan State Pharmaceutical Association, and the matter is being pursued by that Committee.

Resolution 25—Defense of Physician by MSMS. This resolution was referred to the Committee on Utilization Review and Health Insurance Problems which acts as the final appeal body on peer review matters. The Committee reports that the intent of this resolution is incorporated in the "Guidelines for MSMS Peer Review Program."

Resolution 28—Consumer Committee. This resolution instructed MSMS to urge component societies to appoint local consumer committees to help present the medical point of view, and for MSMS to select a statewide committee from the membership of the component-sponsored committees. Articles appeared in *Michigan Medicine* and a letter was sent March 15, 1972, to each component society by the MSMS Committee on Public Relations. Committee members also conferred with some of the component presidents. As of September 1, 1972, MSMS has received no information from any component society that such a committee has been established or is functioning.

Resolution 29—Discrimination against Physicians and Women in Membership on County Hospital Boards. The provisions in law preventing physicians from serving on the boards of county hospitals and limiting the number of women on the board were repealed by House Bill 4902. The objective of this resolution has been achieved.

Resolution 30—Increasing Hospital Contsruction Costs. In February, representatives from the Michigan Hospital Association and the Michigan Association of Osteopathic Physicians and Surgeons met with MSMS and discussed this resolution. A subcommittee with representatives from each group was named to peruse the matter. The subcommittee had not reached conclusions as of this date.

Resolution 32—Laboratory Service for Comprehensive Drug Abuse Treatment Programs. This resolution was referred to the Committee on Alcohol and Drug Dependency. On January 25, 1972, a communication was sent to the Governor's Office of Alcoholism and Drug Abuse, requesting its help in devising a way in which tests to obtain laboratory analysis of street drugs can be run at cost.

Experience in other states has shown that one of the most valuable components of a program to combat drug abuse is free access to a laboratory equipped to identify the composition of unknown drugs, test body fluids for levels of drugs and run tests on the urine of methadone patients to determine that they are taking the methadone and that they are not taking other drugs.

Resolution 36—Unsatisfactory Federal Narcotic Registration Form. This resolution directed the Michigan Delegation to urge the American Medical Association to work toward simplification of the Federal Narcotic Registration Form.

The Delegation introduced a resolution at the November 1971 AMA meeting, requesting AMA to petition the Bureau of Narcotics and Dangerous Drugs to develop a less complicated form and the resolution was adopted by the AMA House of Delegates.

Resolution 37—Physician Participation with Third Parties. A resolution adopted by the House of Delegates in the spring session directed The Council to consider the feasibility of developing a single insurance claim form that can be used or altered by third-party carriers. In separate action the MSMS Council Chairman appointed an ad hoc committee consisting of the President, President-Elect, Chairman of The Council and the Finance Committee Chairman to deal directly with the State on matters of Medicaid.

Resolution 38—Definition of a Specialist. This resolution defined a specialist and was made a part of the Official Policies of MSMS.

Resolution 39—Higher Reimbursement by Blue Shield for Outpatient Surgery Performed in the Surgeon's Office. This resolution was referred to the Committee on Utilization Review and Health Insurance Problems. The Committee reports that as of September 1, 1972, Blue Shield will be capable of reimbursing physicians for work done in their offices according to office charging patterns and if their charge patterns are different from like procedures performed in the hospital, they will be reimbursed accordingly.

Resolution 40—Recommendations for Peer Review. This resolution was referred to the Committee on Utilization Review and Health Insurance Problems which acts as the final appeal body of peer review matters. The Committee reports that the intent of this resolution is incorporated in the "Guidelines for MSMS Peer Review Programs."

Resolution 41—Blue Cross-Blue Shield Coverage for Medical Students. This resolution was studied by the Committee on Professional Insurance Plans. The Committee reported that medical students and their dependents can obtain adequate health care and health insurance through the universities and there is no need to extend coverage to them through the MSMS Group 94000 Blue Cross/Blue Shield program. The Council received this report on June 6, 1972.

The Committee also noted that the only way medical students could become eligible for the MSMS group would be if they became MSMS members. (There are no provisions in the current MSMS Bylaws for student membership.)

Resolution 42—Direct Payment to Medicaid Patients. Since the inception of the Medicaid program, MSMS has constantly tried to convince state authorities that privileges under the Medicaid program should equal those under Medicare. State authorities remain adamant on this issue, although this calendar year benefits for Category 2 patients were increased to equal those of Category 1.

Resolution 43—Direct Payment of National Health Insurance Funds to Patients. This resolution was referred by The Council to the Michigan Delegation to the AMA. The Delegation introduced a resolution at the November 1971 AMA meeting to "encourage future federal health programs to permit direct billing of patients by physicians and allow federal payment of funds to patients when patient and physician agree." The AMA House of Delegates adopted the resolution.

Resolution 47—Exoneration of a Physician from Conspiracy in the Assassination of a President. This resolution regarding Doctor Samuel A. Mudd has been brought to the attention of members of the Michigan Delegation to Congress and to the Senators.

Resolution 48—Home Health Services Under Medicare. The need for increased home health services has been brought to the attention of political leaders at the state and national level. The new Practitioner's Manual under the State Medicaid program provides for part-time nursing services, home health aid services, administration of oxygen, and eligible physical therapy rendered by a home health agency—only with recommendation and authorization of the medical practitioner.

Resolution 49—Membership Priorities. This resolution suggested a poll of MSMS members to determine their opinions of issues, etc. No immediate action was taken because AMA was planning the same kind of survey and it was felt that MSMS should not ask the same questions. The AMA questionnaire was mailed March 31, 1972. There were 94,035 replies or 52.9 percent, which was viewed as an excellent return.

Survey results were reported to the AMA House of Delegates last June. An AMA report contrasting Michigan responses to the national totals was received at MSMS headquarters September 1 and will be distributed to the MSMS House of Delegates. The summary reports the view of Michigan physicians on such issues as principles of practice, national health insurance, professional liability insurance, manpower supply, AMA services, etc.

Several other states are beginning to survey members re opinions and attitudes and MSMS is requesting information about their questions, procedures, etc. MSMS interprets Resolution 49 as being an ongoing policy decision. A survey is being planned for December for distribution through *Medigram* to reduce postage costs.

Resolution 52—Physician Relations with Communications Media. This resolution urged MSMS members to work closely with local news media. An article implementing this resolution appeared in the February 1972 issue of *Michigan Medicine.* A copy of the resolution appeared on the back cover of the Michigan Press Association journal to newspaper editors in June, 1972 as a paid MSMS message, urging greater teamwork between newspapers and physicians.

Resolution 55—Change of DSR Reporting Forms for Blue Shield. This resolution was referred to the MSMS Committee on Utilization Review and Health Insurance Problems which has the matter under continuing discussion with Blue Shield representatives.

Resolution 56—Surveillance and Utilization Review. This resolution authorized continued MSMS participation in the Medicaid Performance, Surveillance and Utilization report system and MSMS representatives have continued to function as members of the Advisory Committee to the program.

Resolution 59—Drug Abuse Control. The Legal Affairs Committee followed legislation closely to enhance a control of drugs and narcotics in Michigan. MSMS actively supported House Bill 4882 which established a State Bureau of Narcotics and Drug Control, one factor of which is the keeping of an inventory by all practicing physicians of dangerous drugs in their possession. House Bill 5858, a bill designed to offer addicts the alternative of obtaining clinical help rather than imprisonment, was reviewed by the Committee on Alcohol and Drug Dependency. Ongoing contact in the development of this piece of legislation continues.

Resolution 60—Medicaid Provision for Preventive Health Health Care Services. Although not all preventive services are yet covered in the new Medicaid program, certain significant additions to services covered have been made. Among these are objections on an out-patient basis, immunizations, Pap smears and prosthetic devices on an out-patient basis.

Resolution 61—Delay by Michigan Blue Shield in Payment of Physician's Services Rendered. This resolution was referred to the MSMS Committee on Utilization Review and Health Insurance Problems which has the matter under continuing discussion with Blue Shield representatives.

Resolution 62—Support of Proposed Policy Declaration on Maintenance of Health and Medical Care of National Chamber of Commerce of the United States. This resolution directs The Council to stay abreast of the National Chamber of Commerce proposed health policy. In addition to AMA's proposed "Medicredit" health insurance measure, MSMS has kept abreast of the Chamber of Commerce proposal, the health insurance industry's proposal, and certainly the Kennedy-Griffith proposal. Included in the Chamber of Commerce contacts are membership in the National Chamber of Commerce and a one-hour visitation at the National Chamber of Commerce Health Office in Washington.

Resolution 63—Medical Education Community Orientation (MECO) Project. This resolution asked that MSMS strengthen its support of the SAMA-MSMS-MHA-MAFP project to place sophomore medical students in community hospitals. The MSMS Department of Communications provided additional staff leadership to this project and 92 students from the three medical schools were placed in 51 communities during the summer of 1972. There also was much more newspaper publicity, etc., than in 1970 when 11 students were placed, or in 1971 when 50 students participated.

Resolution 64—Shortage of Physicians. MSMS played a role in the legislative appropriation of funds which will increase total class sizes in Michigan medical schools in 1972 by 221 students. Major gains are 54 students at the Michigan State University College of Human Medicine, 111 students at the Wayne State University Medical School and 50 students at the University of Michigan Medical School. The remaining gain is at the School of Osteopathic Medicine at Michigan State University.

This resolution also urged that dialogue be continued with the medical schools and medical students toward retaining more of the graduates in Michigan. Resolution 54 called for the same action so the members of the MSMS Liaison Committee with Medical Students and the Education Liaison Committee were named as a special ad hoc committee. The medical schools have begun considerable research and work is continuing. The committee plans a report to the Spring 1973 House of Delegates with specific recommendations.

The resolution also called for MSMS efforts to expand the development of family practice. The three schools this Spring received a federal grant for family practice preceptorships.

Resolution 65—Payment for Voluntary Sterilization. This resolution reaffirming the MSMS policy supporting third party payment for elective sterilization was forwarded to the Michigan Insurance Commissioner as instructed. Copies were also sent to all members of the Michigan Medical Service Board of Trustees.

Resolution 66—Abortion Reform Petition Drive. A single mailing to doctors in Michigan, bringing to their attention the abortion reform petition drive, was made from MSMS headquarters. It informed doctors who are interested in the petition drive how they could participate. The matter of abortion reform will be on the November State ballot.

PART III

MATTERS REFERRED TO THE COUNCIL BY THE SPRING 1972 HOUSE OF DELEGATES

MSMS Audit to Ways and Means Committee. As instructed by the Ways and Means Committee at the Spring 1972 Meeting, the Finance Committee will present audited financial data to the Ways and Means Committee at the Spring Session of the House of Delegates this year and in future years.

Planning and Priorities Committee. In response to a reference committee recommendation that the Alexander Grant Phase II Study be evaluated by the Committee on Planning and Priorities and that the study involve the full spectrum of MSMS, including officers and members of local societies, hospital staffs and others that would be appropriately included, the Planning and Priorities Committee and staff have consulted with American Medical Association personnel and are planning to hold "hearings" of hospital staffs, local society members and others prior to presenting the final recommendations. (See Progress Report of Committee on Planning and Priorities for further details.)

Department of Membership and Member Services. In response to the House-approved recommendation from Council Chairman Masters, a Committee on Membership has been established and several steps have been taken to improve this area of MSMS responsibility. (See Part I of this report for details.)

Resolution 72S-15—Relative Value Study. This resolution approved the RVS as presented by the Relative Value Study Committee and recommended its usage. The RVS is now being printed with five-digit coding and four-digit coding where applicable and will be supplied to all MSMS members when it is available.

Resolution 72S-18—Separate Charter for Gratiot County as a Component Society. This resolution was referred to The Council for investigation and recommendation. The Council's investigation of this resolution revealed that concurrence of the physicians in the Gratiot-Isabella-Clare area in the intent of this resolution could not be reached at this time. Therefore The Council is unable to recommend action on this matter. However it is noted that a resolution on this subject has been introduced in the Fall 1972 House of Delegates so that the House may consider it further.

Resolution 72S-22—Blue Shield Payment for Elective Sterilization. This resolution requested that MSMS work with Blue Shield to accomplish change in policy so that Blue Shield will pay for elective sterilizations. This matter has been referred to the MSMS Committee on Utilization Review and Health Insurance Problems which has it under discussion with representatives of Blue Shield.

Resolution 72S-23—Changes in Workmen's Compensation Rules and Regulations. This resolution urged revision of Workmen's Compensation laws to encourage employment of the handicapped without the employer incurring unfair responsibility for naturally occurring disease processes or aggravation of pre-existing conditions, by a waiver mechanism. The resolution has been referred to the Committee on Legal Affairs for appropriate implementation.

Resolution 72S-24—Single Insurance Claims Form for Third Party Carriers. This resolution has been referred to the Committee on Utilization Review and Health Insurance Problems for study and implementation.

(Addendum to 1972 Annual Report of The Council, MSMS)

September 1, 1972
Dear Fellow Physician:

SUBJECT: COUNCIL ADVICE RE MEDICAID PROVIDER AGREEMENT

This letter contains the awaited MSMS Council advice on the State's Medicaid Provider Agreement.

As you know from reading *Medigram,* The Council August 5 authorized an Ad Hoc Negotiating Committee to confer with the State Department of Social Services and to seek changes in the new Medicaid program. The Ad Hoc Committee, appointed by me as Chairman of The Council, consists of Doctors Sidney Adler, President; John J. Coury, President-elect; Ernest Griffin, Chairman of the Finance Committee, and myself. The Committee reported its work and recommendations August 29 in the enclosed "Report to The Council."

The Council on September 1 approved the report and recommendations.

It now is my responsibility to advise you:

1. Based upon several agreements reached through negotiations, The Council feels that physicians now may wish to sign the provider agreement form. The State has agreed with the MSMS request that physicians have the right to resign immediately from the Medicaid program on written notice. The State also has agreed not to publish the enrollment list of physicians without prior consultation with an MSMS permanent negotiating committee. Other agreements, spelled out in detail in the enclosed pages, also obviate many of the objections voiced by physicians at this time to the provider agreement.
2. In response to our demands, the State Department of Social Services has agreed to a permanent negotiating mechanism with MSMS. The MSMS Permanent Negotiating Committee will consist of five members.

The Ad Hoc Negotiating Committee asked for 23 improvements in the Medicaid program. The State agreed in writing to 18 immediate changes as requested and four of the other five have been referred to the Permanent Negotiating Committee for detailed study and clarification.

Regarding the MSMS requests for a per-case agreement, the Department of Social Services has opted for the single Provider Agreement. MSMS Legal Counsel confirms that this option by the State is legally valid. Therefore, change in this type of agreement as contrasted to per-case agreement will have to come through negotiations with proper authorities in Michigan and at the national level. MSMS will pursue this.

The attached document contains comments from three Department of Social Services letters responding to the 23 requests made by MSMS.

Other objections voiced by physicians are already on the agenda for the first meeting of the MSMS Permanent Medicaid Negotiating Committee with representatives from Social Services.

It is imperative that you read the attached copy of the committee's "Report to The Council" for detailed information.

Very sincerely yours,
Brooker L. Masters, MD
Chairman of The Council

August 29, 1972

MEMO TO: Every Member of The Council

FROM: Ad Hoc Medicaid Negotiating Committee (Doctors Adler, Coury, Griffin, Masters)

SUBJECT: Report of Negotiations with Department of Social Services With Recommendations and Request that each Council Member return Attached Card

The resolution adopted August 5, 1972, at Boyne Highlands by the MSMS Council authorized the Chairman to appoint an Ad Hoc Negotiating Committee to seek certain changes in the Medicaid program. The Committee was constituted to include the four Council members named above.

The Council gave the Ad Hoc Committee full delegation of authority to negotiate and instructed the Committee to report back to The Council as soon as possible concerning such discussions. The Council motion also said The Council was to make recommendations to the membership forthwith after considering the report from the Ad Hoc Committee. The Ad Hoc Committee first met August 10 at the MSMS headquarters with Mr. Stuart Paterson, Mr. Paul Allen and Mr. Thomas Lindsay from the Department of Social Services Medicaid program. A number of changes were sought by MSMS. The State representatives agreed to give further consideration to the requests made by MSMS and to provide a written reply in several days. A reply signed by Mr. Paterson was received August 16 and immediately distributed to the four Ad Hoc Committee members.

On August 22 the MSMS Ad Hoc Committee met alone to review Mr. Paterson's response, and to identify all areas of further concern to the doctors of Michigan.

On August 24, the Ad Hoc Committee reconvened at MSMS headquarters with Mr. Paterson and his staff associates. Previous points were discussed again and some new items were considered.

On August 25 MSMS received a letter from Mr. Paterson agreeing to many of the requests made by MSMS, and explaining the State's position on other matters.

Following is a compilation of the positions voiced by Mr. Paterson in three letters he has addressed to Doctor Masters.

The letters are dated August 2 (a letter distributed to The Council at the August 5 meeting), August 16 and August 25. The subjects cited below are not arranged in any special order of importance.

Fee Determination. The State Department of Social Services has stated that Medicaid fees will track and approximate Medicare fees as of December 31, 1970.

Clarification of the payment mechanism is one of the major gains in the negotiations.

No profiles. Individual profiles have been eliminated.

Fees by Regions. There will be uniformity of fees within four Medicare-determined regions. These are the same as Medicaid regions presently constituted.

Preventive Benefits. Benefits covered by Medicaid have been extended to certain preventive services, including Pap smears and immunization.

Valid Identification. In all cases where an individual has a valid Medicaid Identification Card, the State Department of Social Services will honor all claims for services rendered within the scope of the program if the card is valid at the time the service was given. Physicians will verify the Medicaid card at a regional office of the Department of Social Services.

Immediate Resignation. Effective August 25, the State will honor physician resignations from the program immediately upon written notice.

Permanent "Dialog" with MSMS. The State Department of Social Services agrees to participate in a continuing dialog with the Michigan State Medical Society. Regular meetings with a permanent MSMS committee will be welcomed and suggestions for discussion will be open to anything of interest or concern to the physicians and consumers which relate to the Medicaid program.

Use of Computerized Billing or Billing Services. The State has made accommodations for established computerized billing or billing services. An authorized signature transmitting invoices prepared in this manner is acceptable in lieu of a signature on each form.

Choice of Patients. The physician who signs the provider agreement is *not* bound in any way to accept any Medicaid patients he chooses not to accept.

List of Participating Physicians. It is agreed that the Department will not make a list of enrolled physicians available at this time. Any consideration to do so at a later date will be discussed with the permanent MSMS committee prior to a decision.

Change in Certification Statement on the Invoice. It is agreed that the certification statement will be changed to read: "This is to certify that I have rendered the above medical service. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents or concealment of a material fact, may be prosecuted under applicable Federal or State laws."

Since the initial supply of forms has been ordered and distribution has begun, it is agreed that this change will be effective with the next printing. In most instances this means that the second supply of invoices sent to physicians will contain the revised wording.

Definition of an Emergency. It is agreed that the current definition of an emergency requires review. The State will work with the MSMS Committee in arriving at a more suitable definition in the immediate future.

Adjustments in Invoice Form.

> Items 7 (referring physician's name), 8 (referring physician's type) and 9 (referring physician's code): These may be left blank without affecting the payment process if undue difficulty would be encountered in providing this data.
>
> Item 18 (Medicare Status Code): Where Medicare payment is known, claim may be submitted concurrently noting the anticipated Medicare payment. If Medicare payment is too slow to permit timely billing, Medicaid can be billed, subject to proper adjustment when Medicare payment is received. (We agree to report any duplicate payments (Medicaid or other claims) when the provider receives them and to accompany the report with the excess payment when received. This is part of the agreement and MSMS is awaiting clarification of this statement.)
>
> Item 19 (Health Insurance Claim Number): This will be eliminated from the next printing.
>
> Items 22 (Primary Diagnosis) and 23 (Primary Diagnosis Code): Where true diagnosis has not been satisfactorily determined, item 22 may properly contain a symptom or complaint. Item 23 (coding) is necessary to transmit the diagnostic information into numeric format required by the computer. Of the two items, item 23 is most important; indeed, the primary diagnosis code is a requirement or the invoice cannot be paid. Both items are requested for purposes of redundancy. Claims which are miscoded for any reason can be corrected.
>
> Items 24 (Secondary Diagnosis) and 25 (Secondary Diagnosis Code): These would be left blank when not applicable and their absence will not affect payment.
>
> Items 34 (Medicare paid), 35 (Other Insurance paid), 105 (Medicare Co-insurance) and 106 (Medicare Deductible): The same comments with respect to billing procedures for items 18 and 19 are applicable here; that is, claims may be submitted concurrently noting anticipated payment, and if such payment is too slow, Medicaid can be billed subject to proper adjustment when payment is received. (We agree to report any duplicate payments (Medicaid or other claims) when the provider receives them and to accompany the report with the excess payment when received. This is part of the agreement and MSMS is awaiting clarification of this statement.)

Delivery of Newborn Infants. Delivery will be covered if the mother is an eligible recipient on the day of delivery.

Newborn Infant Coverage. Problems involving special services when required by the newborn infant, are recognized and referred to the permanent negotiating mechanism.

Pharmaceutical Substitutions. No change in the prescription order by the physician can be made by a pharmacist without prior consent of the prescribing physician. Any violation of this policy will be investigated and appropriate action taken.

Confidentiality of Patient Records. The State agrees that the patient's consent is required prior to any examination of their medical records by authorized State personnel unless the patient is deceased or his whereabouts unknown.

With respect to the *Provider Agreement,* MSMS negotiators strongly asserted the State's doctors' outspoken preference for a per case agreement. The State responded by documenting its position in the August 16 letter as one from which it cannot move; that is, the one-time provider agreement is mandatory in Michigan. The State's position, according to MSMS Legal Counsel, is legally valid; therefore, any recourse from this decision must be made at the Federal level (HEW). The Committee believes that the agreements reached with the State obviate many of the objections to the one-time provider agreement, and that efforts to substitute a per case agreement now should be addressed to the Federal level.

The Committee believes that it is The Council's responsibility now to offer guidance and direction to the membership of MSMS. Therefore,

Recommendation One: Based upon the agreements reached by the State Department of Social Services and the Ad Hoc Committee of MSMS, particularly with respect to the right of immediate resignation from the Medicaid program on written notice and agreement not to publish the enrollment of physicians without prior consultation with the permanent negotiating committee, and since the above agreements obviate many of the objections to the provider agreement at this time, the Negotiating Committee feels that physicians may wish to sign the provider agreement based upon the above discussions. MSMS has no objection.

Recommendation Two: The Department of Social Services opted for the single provider agreement. Change in this provider agreement will be through negotiation with the proper authorities.

Recommendation Three: That the Permanent Negotiating Committee consist of five members jointly appointed by the Speaker of the House, the President, and the Chairman of The Council, subject to the approval of The Council, or the House of Delegates if in session, with an annual review of committee membership. The Committee shall report to The Council, or the House of Delegates if in session, before any agreements are ratified.

Enclosed is a return postcard for your vote on these three recommendations. If not received by Thursday, August 31, MSMS will contact you by telephone.

Finally, the Committee wishes to commend the willingness and cooperation expressed by Mr. Paterson and his associates in working out current and future problems between the State Department of Social Services and MSMS.

COMMITTEE REPORTS

15. Annual Summaries of Council Committees

Committee on Aging

Jack F. Sanders, MD, *Chairman*

The Committee met on July 13, 1972.

In 1971, The Council authorized this standing committee, which was then reorganized in membership to revitalize efforts of professional awareness of the medical needs of over 750,000 aged in Michigan.

Following a general discussion on methods to direct practicing physicians' concern and to increase the Committee's advisory and supportive roles on a broad front, a list of Goals and Objectives for 1972-73 were transmitted to the MSMS Planning and Priorities Committee.

Committee on Alcohol and Drug Dependency

Richard C. Bates, MD, *Chairman*

The Committee met on September 15, February 16 and April 19.

The Committee, in conjunction with the Office of Drug Abuse and Alcoholism, State of Michigan, and many other organizations and groups, will sponsor an educational workshop on alcoholism and drug abuse at the MSU Kellogg Center in East Lansing on September 19-20. The Governor will sign the invitations to the workshop and will be one of the speakers at the meeting. Michigan's component medical and osteopathic societies will be requested to send representatives to this meeting to discuss ways to train physician-speakers; to coordinate the various community agencies and groups to form community-wide approaches to education and treatment; and to develop continuing medical education programs for doctors about drug diagnosis, treatment and rehabilitation.

The Committee considered legislative matters concerned with alcoholism and drug abuse; had a special meeting with representatives of the Michigan State Pharmaceutical Association to discuss any problems that pharmacists are having with practicing physicians, and means whereby an offender can be warned and rehabilitated before he is in serious trouble with law enforcement agencies; continued its liaison with the Michigan Department of Public Health, the Office of Drug Abuse and Alcoholism, State of Michigan, and other agencies. A special meeting was also held with representatives of the Michigan State Board of Registration in Medicine to discuss the Board's problems with alcoholic and drug abusing physicians.

Committee on Computers

Robert M. Stow, MD, *Chairman*

This Committee was created by Resolution 17 of the 1971 House of Delegates and charged with keeping abreast of developments in the computer field and advising The Council on needs for legislation, changes in accreditation requirements and other matters which would logically come before the Committee.

The Committee is composed of physicians from the major medical service areas within the state, and plans to coordinate individual efforts toward an eventual integrated statewide hospital and medical information system.

Education Liaison Committee

Brock E. Brush, MD, *Chairman*

Liaison Committee With Medical Students

George H. Koepke, MD, *Chairman*

Joint Summary of Activities, 1971-72

These two committees this year have met jointly on Dec. 16, 1971, March 20, 1972, and Aug. 31, 1972.

The major reason for the joint meetings was because the MSMS Speaker has appointed the members of the two committees to function as a new ad hoc to implement Resolution 54 adopted by the 1971 House of Delegates. The report is limited to these major activities:

1. *Implementation of Resolution 54.* This resolution instructed the Speaker of the MSMS House of Delegates to appoint a committee to study the emigration by some Michigan medical school graduates to other states for internships and residencies and to make recommendations to help minimize this loss. The ad hoc committee, as specified in the resolution, is composed of academic and practicing physicians and medical students. The ad hoc committee discussed the reasons how or why graduating medical students select their internship experiences and discussed reasons why doctors locate or do not locate in Michigan. The three deans, concerned about the same matter, asked the University of Michigan to collect and interpret statistics about the inflow and outflow of graduates of Michigan medical schools, interns, residents and new physicians.

Several preliminary progress reports have been provided the committee, and the deans reported at the Aug. 31 meeting that the research work was still continuing. Computer printout information has been purchased by the medical schools, and information has been obtained from the AMA master files.

On Aug. 31, the ad hoc committee authorized the cochairmen to name a small task force committee to confer with the deans about specific suggestions that the committee could finalize for a report to the Spring meeting of the MSMS House of Delegates. The Speaker's report to the House of Delegates recommends that the ad hoc committee be given additional time to complete its work.

2. *SAMA-MECO Project.* The Committee provided advices and guidance to the MSMS Department of Communications which handled the placement of 92 sophomore medical students for the summer of 1972 in hospitals in communities. This is a sharp increase over the 11 students placed in 1970 and the 50 students placed in 1971. There were a total of 160 students from the three schools who applied. Cooperating in the project again were the 3 SAMA chapters, Michigan Hospital Association and the Michigan Academy of Family Physicians. The Committee has voted to continue the program next year.

3. *Financial Needs of Students.* The committee has discussed the needs of many students for financial help. MSMS Treasurer John Ylvisaker, MD, has been a guest at two meetings and is exploring several ideas with Michigan bankers.

4. *Physician Assistant Program at Western Michigan University.* The committee has received progress reports from WMU at each of its meetings about its successful request for federal funding for a degree-PA-program, which MSMS endorsed several years. WSU enrolled its first class in August. The Committee is continuing to offer advice and guid-

ance to WMU and to the MSMS Legal Affairs Committee re licensure questions.

5. *Preceptorships.* The MSMS Council approved a committee draft of a proposal to the University of Michigan asking that the U-M request on behalf of three medical schools for federal funding under the Health Manpower Training Act of 1972 include a grant to help MSMS place students in not-for-credit arrangements with family physicians. The three schools have received a grant. The possible MSMS subcontract was not included.

6. *Training of Medical Assistants.* The Committee has exchanged correspondence with John Porter, Ed.D., superintendent of the State Department of Education, about the need to train more medical assistants in one-year and two-year curricula at Michigan colleges and community colleges. This discussion will be continued.

Committee on Eye Care
Robert T. Blackhurst, MD, *Chairman*

The Committee met on January 26, 1972.

The Committee continues to serve in an advisory capacity and as resource persons and/or consultants to other members of the profession, other MSMS committees, the Bureau of Maternal and Child Health of the Michigan Department of Public Health, the Division of Services to the Blind of the Michigan Department of Social Services, educators, legislative and government persons, and to other groups, organizations, persons, etc., when advice and counsel on ophthalmological matters are indicated.

The Committee heard reports on and gave recommendations concerning the use of oxygen for prematures; educational materials for diabetic persons; the Lansing dyslexia project; services for deaf-blind children; trainable mentally retarded children; and, library services available to the blind and physically handicapped.

The Committee reviewed the screening programs and other activities of the Vision Section of the Michigan Department of Public Health, Bureau of Maternal and Child Health.

MSMS Committee on Hospital Relations
Lewis E. Simoni, MD, *Chairman*

The Committee met on February 16, 1972, with representatives of the Michigan Hospital Association and Michigan Association of Osteopathic Physicians and Surgeons.

Primary involvement continues to be the Michigan Study of Hospital-Doctor Effectiveness Project to achieve more effective hospital and medical care.

MSMS staff Auer reviewed activities in the nation and Michigan of physician's assistant's training programs.

The Committee is studying Resolution 30, "Increasing Hospital Construction Costs," adopted by the 1971 MSMS House of Delegates, MHA House of Delegates Resolution in October, 1971 related to utilization of obstetrical beds and the Federal Occupational Safety and Health Act. Representatives of MHA, MAOPS and Michigan Osteopathic Hospital Association were appointed to serve on a Subcommittee on Hospital Construction Costs.

The Committee received a report about the MSMS-MHA Workshop on Accreditation Standards held November, 1971.

MSMS co-sponsored a Medical Staff-Trustee-Administrator Forum in May, 1972.

Committee on Medical Aspects of Organized Athletics
Gerald A. O'Connor, MD, *Chairman*

The Committee met March 15, 1972 and most of the committee members also participated in the 1972 MSMS Conference on Medical Aspects of High School Sports, April 12.

The Committee is continuing its study to develop a set of objectives and goals toward better medical care for high school athletes. This project includes (1) better examination record, (2) recommendations for minimum athletic equipment for training and rehabilitation, and (3) suggestions re adequately trained personnel to help the team doctor and coach. The committee also recognizes medical problems that are surfacing as more and more schools engage in organized athletics for girls.

The Committee sponsored the 1972 MSMS conference for coaches, trainers, and team doctors at the Towsley Center, University of Michigan Friday, April 12 in connection with the U-M spring football game.

Committee on Medicine and Religion
Winslow G. Fox, MD, *Chairman*

As part of the Annual Session, the Committee will hold a joint meeting with representatives from county medical societies, who are concerned with effective care of the patient as a whole person. It is intended that this meeting will serve as a model for similar dialogues between physicians and the clergy at the county society level.

Liaison Committee with the Michigan State Pharmaceutical Association
Robert E. Rowe, MD, *Chairman*

Physician members of the Liaison Committee met on March 15, 1972. This was necessitated due to an inability to schedule a joint meeting with MSPA representatives and a requirement to consider Resolution 24 of the MSMS 1971 House of Delegates.

The Committee reviewed Michigan Board of Pharmacy Rule 16 (c), the MSMS Resolution mentioned above and Resolution 1 of the 1971 Michigan Hospital Association which would permit registered nurses to dispense medications under certain conditions.

The MSMS Council approved a Committee recommendation on April 26, 1972 amending the MSMS Resolution. The adopted Resolution, as amended, reads: "That the State of Michigan Board of Pharmacy provisions be amended to allow registered nurses, on written policies and procedures adopted by the hospital pharmacy and/or therapeutics committee, to dispense medications ordered by a qualified physician in the absence of a registered pharmacist." The Board of Pharmacy was advised of The Council's action.

The Committee objected to an article in "Michigan Pharmacist" which advanced the hypothesis that pharmacists were capable of "a new philosophy for the direction of professional practice; namely, the patient consultation on a private, by-appointment basis." The Council received a copy of these objections for information.

The Committee objected to the Michigan Board of Pharmacy about a pharmacy in Jackson conducting a cut-rate campaign to induce patients to request physicians to write new prescriptions even though the current prescription is renewable. The Board of Pharmacy responded that this campaign, although unprofessional, is not illegal because the Attorney General ruled there can be no prohibition of advertising for economic advantages.

Goals and Objectives for 1972-73 were forwarded to the MSMS Planning and Priorities Committee.

The Committee thanked the Student American Medical Association for supporting anti-substitution legislation.

Committee on Rehabilitation
Stuart L. Cohn, MD, *Chairman*

The Committee met on October 13 and May 11.

For some time, the Committee has endeavored, by different means, to get a picture of the peripheral difficulties facing the position of rehabilitation and physical medicine. These difficulties have been brought about by the increasing attention to long-term illness, particularly as applied to people over age 65, under the terms of the Medicare Act, the Extended Care Act and the Medicaid Provision.

The Committee recognizes that chronic disability is a major health problem in the United States and that the rules and regulations developing from the Medicare legislation and their interpretation in the various states are a deterrent to the development of meaningful programs of rehabilitation.

After many discussions and meetings with representatives of other groups and consideration of the 1970 House of Delegates Resolution 45 entitled "Rehabilitative Care," the Committee appointed a study committee to define rehabilitation and establish guidelines for rehabilitation services.

Inasmuch as Doctor Edwin L. Harmon of the Michigan Department of Public Health was charged with the responsibility of developing guidelines for rehabilitative care, the Committee felt that collaboration on the part of both parties would prove to be mutually practical and beneficial.

In a Special Report to The Council, the Committee requested The Council to approve its working with Doctor Harmon and his committee in writing guidelines for the development of rehabilitation services. The recommendation of the Committee was approved by The Council and Joseph N. Schaeffer, MD, of Detroit, was appointed the Committee's representative to Doctor Harmon's committee.

The Committee is also working toward having the word "rehabilitation" defined whenever written into any permanent legislation, and the word "rehabilitation" used in place of the word "restorative."

Committee on Relative Value Study
MICHAEL N. ZELENOCK, MD, *Chairman*

The Committee held meetings on December 8, 1971 and February 9, 1972.

The charge of the House of Delegates to complete the final two sections (Medicine and Eye) was fulfilled. The Committee submitted its report to the spring session of the House of Delegates. The report was approved and the 1971 Michigan Relative Value Study was adopted.

The Committee members have continued their editing efforts on the Study.

The Council of MSMS has directed the Relative Value Study Committee to print the 1971 MRVS utilizing both the five-digit A.M.A. Current Procedural Terminology, and the four-digit National Assn. of Blue Shield Plan's coding.

Ad Hoc Liaison Committee with Special Legislative Study Committee on Malpractice Actions and Professional Liability
FRANK B. BICKNELL, MD, *Chairman*

The Committee met several times with members of the Malpractice Committee of the Michigan Association of Osteopathic Physicians and Surgeons. The two groups jointly searched for legislative means of alleviating the malpractice insurance problem in Michigan. It advised the joint Legislative Committee to study medical and hospital malpractice. Doctor Weissman was appointed to an Advisory Committee to the Legislative Study Committee. The Legislative Study Committee is to report to the Legislature in January of 1973.

Liaison with State Bar of Michigan
RICHARD C. REILLY, MD, *Chairman*

This Committee did not meet because no matters were referred.

16. Annual Summaries of Standing Committees

Ad Hoc Committee on Medical Examiner System
WILLIAM DEYOUNG, MD, *Chairman*

This ad hoc committee was appointed under the aegis of the Legal Affairs Committee and charged with taking steps to implement the medical examiner system subject to Public Act 92 of 1969. The Committee held regional meetings in cooperation with the Osteopathic Association in Jackson, Grayling, and Grand Rapids. Each meeting, except for the Grayling meeting, attracted approximately 20 physicians. It became obvious from the attendance at the meetings that there was significant interest in implementing the medical examiner system.

The Committee reported to The Council on November 9, 1971, that it felt it had achieved its purpose and that further implementing steps should be taken within the standing committee structure of the Society. Therefore, in December of 1971, The Council discharged the Ad Hoc Committee on Medical Examiner System.

Advisory Committee to the American Association of Medical Assistants, State of Michigan
BARRY H. ALFORD, MD, *Chairman*

The American Association of Medical Assistants, State of Michigan, has been active and successful at both a state and national level during the past year.

At the most recent national convention, Michigan ranked second only to California in membership. Five Michigan Medical Assistants were selected for national committee positions. Betty Lou Willey of Port Huron, will be running for election as National Vice-President at the next national convention.

In April of 1972, the State convention of the American Association of Medical Assistants, State of Michigan, was held in Kalamazoo, Michigan. The meeting of the House of Delegates, was followed by a scientific program and the installation of officers. Margaret Broadwell of Detroit, became the State President for 1972-73.

The medical assistants of the State of Michigan have been active in supplying education programs for their membership.

Audrie Chute of Royal Oak, the State President elect, was chairman of a summer educational seminar held at Schuss Mountain in July.

A Leadership Training Seminar will be held in Lansing in September.

Throughout the year, the local component chapters have held their own educational meetings.

The American Association of Medical Assistants has an educational program approved by the AMA Council on Education. Those who are able to pass a specified test become Certified Medical Assistants. The State of Michigan now has eighteen medical assistants who have successfully achieved this title.

This is an active, vigorous organization that has as its primary purpose the educational advancement of its members. The Constitution and by-laws of both the national and state organizations state specifically that it is not and shall never become a union.

These groups are sponsored by the AMA, on a national level and by MSMS, on a state level. All physicians will benefit by having their medical assistants belong to this fine organization. Your financial and moral support on the local level will help to improve your office efficiency and professionalism.

Advisory Committee to Woman's Auxiliary
CHARLES A. SCHOFF, MD, *Chairman*

Again this year, as for many years in the past, there has not been a formal meeting of the Advisory Committee to the Woman's Auxiliary to the Michigan State Medical Society. However, the members were polled on one very pertinent question . . . whether the Auxiliary should hold its Annual Convention at some site other than in downtown Detroit. This question was raised because of the rapidly rising costs and the difficulty in obtaining a satisfactory site. The poll resulted in a tie vote, so the question was not pursued at that time.

Members of the Auxiliary have again proven that they are not primarily socially oriented, but that they are a group of well informed, devoted women dedicated to assisting MSMS in its programs for the advancement of medicine and health education.

The April 19 Legislative Day was one of the highlights of the year's program. Held again at the Olds Plaza Hotel in Lansing, the attendance was the largest on record with 85 women, 55 legislators and 15 staff members and other special guests present.

Contributions by the women to AMA-ERF were increased this year over last year compared to a marked decrease in contributions by members of MSMS. Most county societies maintain and support a scholarship or student loan fund. These and many other projects, both state-wide and local, have combined to make 1971-1972 a very successful year.

If the program of the Auxiliary is to continue to flourish, it is essential that the wife of every physician be an active member of Auxiliary. This can be accomplished most effectively if each member of MSMS encourages his wife to become a part of Auxiliary.

Committee on Cancer
Max E. Dodds, MD, *Chairman*

The Committee met on November 17, 1971 and on June 14, 1972.

Liaison has continued with the member-organizations of the Michigan Cancer Coordinating Committee: the Michigan Cancer Foundation, the Michigan Department of Public Health, the Michigan Dental Association, the Michigan Health Officers Association, the American Cancer Society, Michigan Division, Inc., the Michigan Association of Osteopathic Physicians and Surgeons and the Michigan Association for Regional Medical Programs.

The Committee had discussions on the Pap test and Ortho's product PAPette; hospital tumor registries; evaluation of Mitogillin; and, the "Diagnosis and Management of Four Neoplasms" report compiled by the Michigan Association for Regional Medical Programs.

The Committee re-wrote its "Purposes" and discussed whether or not it should assume responsibilities regarding the establishment of cancer committees in all major hospitals throughout the state; the identification of diagnostic and treatment centers in outlying communities; the review of methods of consultation and patient care; and, the establishment of a closer liaison with the osteopathic hospitals.

Committee on Child Health and Welfare
John M. Dorsey, Jr., MD, *Chairman*

The Committee met on February 16 and June 27.

The Committee held discussions on the following matters: restraint in the production of drugs and alkaloids; juvenile diabetics; the use of non-licensed personnel; neo-natal mortality; migrant health care; premature intensive care units; pediatric units in general hospitals; wrestling weights; smallpox vaccinations; day care health form; FDA rulings and subsequent publicity; physicians' assistants programs; safety glass legislation; the Guthrie test; and, other items.

A study is being conducted on wrestling weights and the Committee hopes to be able to set forth some recommendations that can be adopted by the Michigan State Medical Society.

Another study is being done regarding educational material for diabetic patients.

Information on Michigan hospitals with premature intensive care units is being gathered and an article will be written for publication in *Michigan Medicine.*

Committee on Governmental Medical Care Programs
Robert E. Rice, MD, *Chairman*

The Committee met on November 18, 1971, February 2, 1972 and April 12.

The Committee analyzed several matters involving governmental medical care programs during the year; to wit: HMO feasibility from the physician's viewpoint—The Medicus Corporation offered to conduct a statewide feasibility study from the physicians' viewpoint of health maintenance organizations. After several meetings with the Corporation the Committee reported to The Council that it felt the program was beyond the scope of MSMS at this time, but offered to serve as an intermediary if component societies desired feasibility studies within their areas.

National Health Service Corps, MSMS Involvement—This new Federal program provides physicians from the United States Public Health Service to serve in areas identified by the Government, with local and state medical society endorsement, as critically short of physicians. The Committee addressed itself to the proper procedure whereby State and County Medical Societies could advise those areas seeking National Health Service Corps physicians. A procedure was recommended and adopted by The Council whereby component medical societies will be contacted when State Society endorsement is required of a NHSC project. MSMS determination will be consistent with decisions of the component medical society.

Psychiatric Services under National Health Insurance Plans—After study, the Committee recommended, and The Council accepted, a position whereby MSMS advocates "That any system of National Health Insurance should provide the benefits for mental and emotional disorders to the same degree and extent as for any other illness." Subsequently, the AMA took a similar position.

New Delivery Systems in Michigan—The Committee endorsed a program in which staff visited and interviewed at eight new or evolving health delivery systems in Michigan with major governmental investment. Reports of these visitations and observations were made via *Michigan Medicine.* The Committee will receive staff reports of return visits of evaluating these programs of progress, or lack of progress, at these and other new centers.

National Health Insurance—Action '72—AMA requested that the Task Force on National Health Insurance be formed to serve as a clearing house of information at State and component society levels. The Committee recommended, and The Council concurred, that an ad hoc committee to work with AMA on national health insurance be formed, involving the Governmental Medical Care Programs Committee and Committees on Legal Affairs, Public Relations, the AMA Delegation, and members-at-large.

Projects of a special nature initiated by the Committee included two cooperative efforts with the Committee on Legal Affairs; a joint meeting November 18, 1971, with Mr. Stuart Paterson, Director of the State's new Medicaid Program, and a meeting February 24, 1972, with the Social Services Subcommittee of the Michigan House Appropriations Committee.

The Committee also met with Doctor Thomas Batchelor, MD, Director, Model Neighborhood Comprehensive Health Program, Detroit; and, John Mucasey, MD, Director, Woodland Medical Center, Inc., Detroit.

The Chairman of the Committee attended an AMA briefing and meeting with Michigan Congressmen in conjunction with the Wolverine State Medical Society and the National Medical Society August 1-2, 1972.

Committee on Highway Injury
Paul W. Gikas, MD, *Chairman*

The Committee met on December 13, 1971.

The MSMS Council rejected a recommendation that MSMS support the position of the Medical Society of New Jersey that "emergency medical care be given high priority on the National level and that Federal authorities be urged to provide adequate funds to administer a comprehensive program."

The Planning and Priorities Committee received the 1971-72 Goals and Objectives seeking improved snowmobile construction and training of operators; cooperating in categorizing hospitals capable of providing emergency medical services; advising component medical societies of availability of training programs in emergency medical care; continuing support of the State's Medical Evaluation and Advisory Group and, cooperating with interested groups about medical aspects of highway crashes and injury prevention.

Doctor Arthur Dundon served as a member of the Department of State's Task Force on Licensing, Driver Controls and Coordination which seeks to eliminate the problem driver by legislative and/or administrative action.

The Committee continues to investigate the possibility of ambulance service as a benefit of prepaid health insurance policies. An inquiry was directed to the Michigan Ambulance Association seeking information on ranges of fees charged.

Liaison and participation in the Michigan Emergency Services Health Council (MESH) continues.

The Committee seeks clarification from Michigan's Attorney General regarding medical-legal limitations on nurses and ambulance crews when rendering life-saving procedures, whether or not under the direct supervision of a physician. The Committee will review the medical practice acts from Connecticut and Florida for possible similar legislation in Michigan.

Committee on Hospital Privileges
Francis P. Rhoades, MD, *Chairman*

As authorized by The Council in 1971, the Committee stands ready to assist any MSMS member who is dissatisfied with his present staff appointment and/or staff privileges.

The Committee did not receive any requests for assistance during 1972.

Committee on Legal Affairs
Kenneth H. Johnson, MD, *Chairman*

The Committee on Legal Affairs met four times in the current fiscal year, and once in the previous fiscal year subsequent to the last annual meeting of the House of Delegates.

The Committee's objectives for 1972 were highlighted by an effort to achieve revision in the Michigan Medical Practice Act and repeal of the 35-year-old Basic Science Act. The Committee also reviewed bills affecting medicine and health services as they appeared before the Legislature and worked closely with the volunteer Doctor-of-the-Week program.

The Committee was pleased that total repeal of the Basic Science Act was achieved in the 1972 legislature. This bill had been introduced through MSMS sponsorship several times previously. The Committee this year particularly recognizes the assistance of AFL-CIO, UAW, the State Board of Registration in Medicine and the Department of Mental Health in achieving the repeal. The House passed the bill 96-6 and the Senate, 35-1. Governor Milliken signed the repeal into law June 16.

Considerable effort was put into the revised Medical Practice Act in co-sponsorship with the Board of Registration in Medicine. The bill was amended and reported by the House Committee on State Affairs and re-referred to the House Committee on Appropriations. When the Legislature adjourned for the summer recess, the bill remained before the House Appropriations Committee. The outlook for passage this year is dim. The major provisions of the Medical Practice Act revision would be:

(1) Modernization of the language originally written in 1899; (2) certification of physician's assistants by the Board of Registration in Medicine, (3) provision for limited license for some physicians, (4) the "Sick Doctor Act," (5) changes in educational requirements to coordinate with modern medical education, and (6) establishment of an Advisory Committee to the Board consisting of three laymen and two physicians.

Physician's assistant legislation took two forms in 1972. Neither passed as of the Summer recess. One approach, via the proposed revision of the Medical Practice Act, would certify physician's assistants to specific physicians by the Board of Registration in Medicine. This provision failed in committee hearings and was stricken from the bill. The second approach, substitute House Bill 4056, calling for a protracted study of educational requirements for physician's assistants, was adopted by the House and is on the floor of the Senate for adoption in the Fall Session.

Legal Affairs Committee took an active interest in the appropriations bill for the Department of Social Services, which includes the Medicaid program. The Governor's budget recommendation included a proposal for a 3% discount on all Medicaid bills paid within 30 days. In February, the Legal Affairs Committee arranged a working meeting with the Subcommittee on Social Services of the House Appropriations Committee. Speaking for physicians were Charles Vincent, MD, of Detroit; Thomas Berglund, MD, of Kalamazoo; and Robert E. Rice, MD, of Greenville, presenting the legislators with viewpoints from metropolitan, middle urban, and rural areas. Partly as a result of this and several other conversations with legislators, the 3% discount of Medicaid billings did not occur. Pertinent to this issue also were direct conversations with the Governor, who in a letter to Robert Prophater, MD, Chairman of The Council's Legislative Policy Committee, announced to Michigan doctors that he had withdrawn the 3% discount recommendation. Input by physicians on the Department of Social Services' appropriation bill was also reflected in the line item for Medicaid at approximately $72 million for Fiscal 1972-73, representing an increase of some $18 million over the previous Fiscal year (mostly to deal with anticipated case-load increases).

Funding for medical colleges in Michigan is reflected in the Higher Education Appropriations bill whereby Michigan State University College of Human Medicine will show an increase in the Fall of 1972 of 54 students, Wayne State University College of Medicine will show an increase of 111 students, the University of Michigan School of Medicine will show an increase of 50 students.

The Committee also followed closely the development of a Legislative Study Committee on Medical Malpractice and a Citizens Advisory Committee to assist the Legislative Study Committee. The Citizens Committee has met three times with no progress report to date.

Other matters of interest to physicians before the 1972 Legislature included the following:

1. Certificate of Need legislation was passed whereby health facilities in Michigan must obtain a "certificate of need" from the Department of Public Health prior to construction, alteration or remodeling. A companion bill requiring Michigan Hospital Service (Blue Cross) to contract with any licensed hospital in Michigan was also passed.

2. House Bill 5305 and other measures which would establish the Uniform Fee Schedule for Medicaid payments did not pass.

3. A House-Senate Committee authorized to study the need and method of resolving the shortage of general practice physicians in Michigan has not materialized.

4. Senate Bill 3—the abortion reform measure—passed the Senate and died in the House Committee on Social Services and Corrections. Abortion reform later became a referendum issue on the November ballot.

5. Senate Bill 77, which permits medical examiners to designate lay delegates to go to the scene of a death for investigation was passed and signed into law. This bill provides that the lay investigator may go to the scene of a death and make reports. The autopsy and final report shall be filed by the medical examiner. This becomes important to doctors in Michigan serving as medical examiners, or deputy medical examiners inasmuch as the medical examiner bill, pushed hard in the late 60's by the State Medical Society, takes effect January 1, 1973.

6. House Bill 4902, to reorganize boards of county hospitals, included provisions for physicians to sit as board members of hospitals. This legislation achieves the goal of Resolution 29 of the 1971 House of Delegates.

7. House Bill 5727, requiring physicians who diagnose lead poisoning cases to report same to the County Department of Public Health, was adopted.

8. Senate Bill 1209, which eliminates the requirement that hospital review committee organizations must be certified by the Department of Public Health before court immunity is granted, was passed. This means that hospital review committees, individually and their records, are immune from subpoena if subsequent litigation ensues.

9. House Bill 4882, supported by MSMS, which establishes a state narcotics control system, was passed. Further legislation in the area of drug abuse can be anticipated, and pursuant to committee recommendation,

Doctor Richard Bates, MD, Lansing, Chairman of the MSMS Committee on Alcohol and Drug Dependency, will work with legislators in developing further drug abuse legislation.

10. MSMS supported appropriations request by Lafayette Clinic for a $1 million special appropriation to intensify basic research in schizophrenia. The Mental Health Department appropriation bill passed with a $500,000 line item for this particular research at Lafayette Clinic.

The Committee was involved in several special activities throughout the year. Among these were a joint meeting with the Committee on Governmental Medical Care Programs in November at which Stuart Paterson, Director of the Medicaid program for the Department of Social Services, outlined the working mechanisms of the new Medicaid program. Mr. Paterson's comments were subsequently printed in *Michigan Medicine*. The Committee undertook the dinner meeting with the Subcommittee on Social Services of the House Appropriations Committee previously referred to. The Committee sponsored a meeting May 10 with members of the Senate Appropriations Committee. The Committee cooperated with the Committee on Governmental Medical Care Programs in developing a response for The Council to a working draft of "Guidelines for Health Maintenance Organizations" proposed by the Department of Public Health. The Committee was involved in two conferences with Governor Milliken.

The Committee wishes to express its gratitude to the 20 doctors who served the Society as Doctor-of-the-Week during the legislative session. This program continues to be well supported by doctors in Michigan and to be well received by members of the Legislature. The Committee also thanks several physicians who came to Lansing to testify on particular pieces of legislation wherein they had particular expertise, notably, C. Allen Payne, MD, Grand Rapids; Don W. McLean, MD, Detroit and Frederick Van Duyne, MD, Flint on the Medical Practice Act; Thomas Berglund, MD, Doctor Rice and Doctor Vincent on Medicaid; William DeYoung, MD, Saginaw, on Medical Examiner system; Franklin Troost, MD, Holt and Wil Maldonado, MD, Lansing on Basic Science Repeal; and Rosser Mainwaring, MD, Dearborn, on Hepatitis and Blood Transfusions.

Committee on Maternal and Perinatal Health
Richard T. Mellis, MD, *Chairman*

The Committee held meetings on September 16, January 6, March 29 and on May 18-19. Many meetings of the subcommittees were also held.

The Annual Michigan Conference on Maternal and Perinatal Health was held for the eleventh year and was again a successful postgraduate endeavor.

The yearly postgraduate meeting for the members of the Committee and interested guests was held at the MSU Biological Station at Gull Lake in May.

The Committee continued its publication of desk reference cards for use by individual physicians and hospitals; its sponsorship of the Conference for Expectant Parents; its liaison with the Michigan Department of Public Health and the Detroit Maternal and Infant Care Project; its sponsorship of the Placental Tissue Registry; and, its work in connection with maternal and death case histories, maternal mortality, perinatal morbidity and mortality, professional and lay education, abortion reform, and the regional maternal mortality meetings and studies.

Special studies, such as the use of silver nitrate ampules, more information regarding diagnosis on stillborn certificates, the classification of causes of stillbirth, intensive care nurseries, and others were undertaken by the Committee.

The Subcommittee on Better Utilization of Obstetrical Beds feels there is an obvious need for physicians, hospital administrators and governing bodies, consumers and other concerned individuals to become more knowledgeable in the planning and provision of obstetrical and newborn services to assure the availability, quality, efficiency and effectiveness of those services. The Committee received approval from The Council to reactivate its activity in stimulating and coordinating such an educational effort. The Subcommittee has no legal or regulatory authority or function. Rather, the Subcommittee hopes to provide assistance to physicians and others involved in the health planning process at the community level, particularly as that planning relates to provision of obstetrical and newborn services.

Committee on Medical Socio-Economics
Dale L. Kessler, MD, *Chairman*

As directed by The Council, the Committee on Medical Socio-Economics is investigating current mechanisms used by various health insurers to reimburse physicians.

The Committee began its study with the Blue Shield UCR Program (Usual, Customary and Reasonable Program). The Committee met with Blue Shield officials and it was agreed that the following three aspects of the UCR Program needed refinement:

1. *The Entry Level Profile of a New Doctor.* Appropriate guidelines should be developed to determine beginning profiles for new doctors that are fair to doctors who have established charge histories.
2. *Immediate area adjacent problem.* Current prevailing area boundaries are drawn on county lines and sometimes divide a medical service area. Refinements should be made in area boundaries.
3. *Limitations on Permitted Fee Increases for Doctors who request Fee Increases on an Infrequent Basis.* Doctors who do not update their profiles on a regular basis are now being penalized. Provisions should be established that will enable these doctors to be treated equitably as well as doctors who request fee increases each year.

The Committee plans to continue its investigations and will report its progress to The Council on a regular basis.

Committee on Mental Health
Benjamin Jeffries, MD, *Chairman*

The Committee met on February 9, 1972, and May 17, 1972.

A subcommittee to study future involvement and responsibilities related to legislation, liaison and relationships with other specialties and MSMS met on March 22, 1972.

Major concerns involved 1) the difficulty in considering legislation when other committees have similar responsibilities; 2) recommendation to the MSMS Council that two psychiatrists be appointed to the Legal Affairs Committee; 3) a recommendation to the MSMS Council that a Committee on Mental Retardation be appointed and the relevance of mental health and mental illness to general practitioners and non-psychiatric specialists.

The Committee plans a re-alignment of membership to include active, participating psychiatrists and non-psychiatrists. Also discussed was appointment of committee members to serve as liaison and communication with other MSMS committees having special interest and involvement in problems of mental health.

The Committee transmitted a Special Report to the Planning and Priorities Committee of Goals and Objectives for 1972-73.

Committee on Occupational Health
Duane L. Block, MD, *Chairman*

The Committee met on June 19, 1972, and discussed the impact that the Occupational Safety and Health Act of 1970 will have on the practice of medicine. This legislation imposes responsibilities on the physician both as an employer and as a provider of services in the field of occupational health.

The American Medical Association has prepared an excellent analysis of this Act for the benefit of physicians and at the request of the Committee, an announcement was published in *Medigram* urging MSMS members to request a copy of the AMA Analysis.

Committee on Postgraduate Medical Education
Harry A. Towsley, MD, *Chairman* and
Neal A. Vanselow, MD, *Vice Chairman*

The Committee met on April 5, 1972.

Correspondence from the American Medical Association, Department of Continuing Medical Education, suggesting that the State Society plan a program of accreditation for state and local continuing medical education programs was considered. In a Special Report, the Committee recommended to The Council that it authorize steps to establish an accreditation program for continuing medical education programs in Michigan.

The Committee updated its "Purposes"; considered the report of the Ad Hoc Committee on the Medical Examiner System; and conducted its usual postgraduate program throughout the State in the autumn of 1971 and is arranging a like program for the autumn of 1972.

The Committee is in agreement that the Michigan State Medical Society could well help to identify the specific educational needs of its members; be a facilitator of the instructional process; set standards for participation in continuing medical education; provide consultation to groups providing educational programs to be sure such programs are a high quality; and continue to sponsor some educational programs in areas of the state which are educationally underserved.

Committee on Professional Insurance Plans
Robert M. Stow, MD, *Chairman*

The Committee held meetings on February 9, 1972, March 19, 1972, May 17, 1972, June 15, 1972, and September 20, 1972.

Blue Cross/Blue Shield for Widows of MSMS Members. The Council approved a recommendation of the Committee that widows of MSMS members be allowed to continue their coverage under the MSMS 94000 Group subject to certain limitations; such as, remarriage to a non-physician, etc. The Committee is aware that this inclusion might affect the experience rating of the 94000 Group and result in higher premiums, but feels that this consideration is outweighed by the obligation that MSMS has to make adequate health insurance coverage available to widows of deceased members.

Blue Cross/Blue Shield Low Cost Option Program. At the request of the Committee, Blue Cross and Blue Shield are developing new low cost option programs as alternatives to the existing MVF programs.

Disability Insurance for Interns and Residents. The Committee recommended and The Council approved the broadening of the MSMS Group Disability Insurance program by offering disability coverage at a reduced premium to interns and residents under age 34, who become associate members of MSMS.

Professional Liability Insurance. The Committee is disappointed that Johnson & Higgins was unable to develop a professional liability insurance program to be considered for adoption by MSMS. The Council has authorized Johnson & Higgins to continue its study on a non-exclusive basis and the Committee will continue its efforts to develop a viable program for consideration by The Council.

Committee on Public and Environmental Health
Louis R. Zako, MD, *Chairman*

The Committee met on September 1, February 9 and May 24.

The Council approved the Committee's recommendation that a communication, expressing the concern of Michigan physicians regarding the rapidly increasing use of "disposal" items in hospitals and other areas of medical practice, be sent to all hospital directors and hospital purchasing agents, the Governor, and to the proper committees of the Michigan Legislature. This recommendation is in compliance with a 1970 House of Delegates resolution.

A communication was sent to the U.S. Department of Agriculture requesting them to develop a technique to identify a dangerous food product. The Committee feels that it is not so important that there be a date that the product was first put on the market, but that it is very important that the product be handled properly until it is purchased. As it is now, the consumer cannot tell whether or not a frozen food item has been kept at the proper temperature, if it has thawed, or been refrozen.

The Committee is sponsoring a Conference on the Physician and Environmental Quality Control in November. The meeting will be held in Detroit and is for representatives of medical associations and other concerned persons. This conference is a result of the first meeting organized by the Ontario Medical Association in 1970.

The Committee also reviewed and discussed patient isolation; nuclear power plants; venereal disease; the use of combined vaccines; the burn prevention program in Detroit; teaching of tuberculosis care in Michigan's medical schools; transfusion reactions; gonorrhea in the female; smallpox vaccinations; disease control activities; Salmonella infection; and, the MARMP Chronic Respiratory Disease Program Plan.

The September meeting of the Committee was held in conjunction with the Annual Meeting of the Michigan Health Officers Association.

Committee on Public Relations
Thomas R. Berglund, MD, *Chairman*

The Committee met on January 12 in Detroit and May 24 at the MSMS Headquarters.

The Committee initiates and directs many MSMS activities in the public relations area and also advised the MSMS staff on communications work authorized by the MSMS Council.

The report will be divided into several subject-matter areas:

1. *Implementation of 1971 MSMS Resolutions:*

A. *Resolution 28* urged county societies to set up advisory consumer committees. A copy of the resolution was mailed to each county society and staff conspired with a number of components about this idea. The Committee knows of no committee that has been organized but the resolution did serve to alert component societies about the importance of considering the consumer point of view as the doctors selected projects, made public statements, etc.

B. *Resolution 52* urged doctors to cooperate more with the media. An Article quoting from this resolution appeared in *Michigan Medicine*, a copy of the resolution was sent each component, and the resolution appeared as an ad on the back cover of *Michigan Publisher*, the trade journal for newspaper editors.

C. *Resolution 64* urged MSMS to support expanded medical school enrollments. This has been done, often in collaboration with the MSMS Legal Affairs Committee. A cooperative ad by MSMS and the Wayne County Medical Society appeared in the special *Detroit News* issue that praised Scott Hall at WSU stated the MSMS concern for larger medical school classes.

2. *MSMS Efforts to Strengthen PR Work in Wayne-Oakland-Macomb Counties:*

The Committee meeting in January was held deliberately in Detroit so some special guests from the three component societies and WSU medical school could participate. MSMS staff has met throughout the year with leaders of the three counties and with media people there to expand communications efforts. This work will be continued.

3. *Alexander Grant Study:*

The Committee studied the PR comments in the Phase II study by the Alexander Grant firm and an interpretative article appeared in *Michigan Medicine*.

4. *Smoking-Health Project:*

The MSMS Council had referred to the PR Committee the recommendations from the Committee on Cardiac Disease that MSMS become active again in a no-smoking effort. The PR Committee subcommittee went a step further and the program outlined to The Council, and approved, included a recommendation that every doctor stop smoking cigarets. The staff carried out the plan by writing to every hospital and every hospital gift shop operator to halt the sale of cigarets and to ban smoking in most areas of the hospital. The Committee printed a tear-out poster in *Michigan Medicine*, stating, "We Thank You for Not Smoking" which doctors were urged to post in their reception rooms. Materials were offered to junior high school principals with good response.

5. *Venereal Disease Educational Effort:*

The Committee and staff implemented various activities at the direction of the MSMS Committee on Public Health. A $500 grant from the Michigan Department of Public Health made it possible for MSMS to distribute thousands of folders to schools and youth groups, to write to high school counselors, etc. This work was concentrated in the counties with the most evidence of mounting VD.

6. *MSMS-WUOM Radio Series:*

This project was greatly improved during the year. For the first time, new programs have been presented each week, with a backlog of several tapes always ready. Paul Werner, a former radio announcer and now a medical student at Michigan State University, serves as the moderator and tapes most of the programs at MSU. William Ledger, MD, member of the U-M medical school faculty, also contributed several programs before moving to California. WUOM continues to distribute the MSMS tapes to about 35 Michigan radio stations. Programs dealt generally with subjects being covered by MSMS committee or Council work, or with timely health messages that tied in with the seasons.

7. *Ad Hoc Task Force on National Health Insurance:*

The Public Relations Committee has appointed a member to work with representatives of other concerned MSMS committees as this educational effort develops nation-wide under the direction of the AMA.

8. *Emergency Medical Care Educational Efforts:*

The Council approved a joint publication with the Michigan Hospital Association and the Michigan Chapter of the American College of Emergency Physicians, and plans have been made to distribute brochures this fall. The copy suggests to people how to obtain a family physician and how to use the emergency room.

9. *Possible Speakers Bureau re Costs of Health Care:*

The PR Committee and the Committee on Medical Socio-Economics are developing speech material and planning a speakers training seminar in the fall. It has been suggested that speakers first appear before the medical assistants, auxiliaries and component societies to provide up-to-date information and interpretation. Tentative plans are to place experienced MD speakers before non-medical groups later.

10. *"Horizons Unlimited" Booklets:*

MSMS purchased 2,500 more copies of the AMA pocketbook career guide, "Horizons Unlimited" for 5 cents each. The 9,000 copies purchased in 1971 have all been distributed to schools, libraries, etc., and at career fairs, etc.

11. *PR Committee Hearing and 1973 Planning:*

The Committee on May 24 invited component society presidents, special society presidents, medical school deans, executives of voluntary health agencies, etc., to present public relations ideas for 1973. Thirteen ideas were recommended by guests and Committee members, and five projects were selected for further development. The hearing was directed by Thomas Payne, MD, PR Committee member. The Committee feels these five areas need special attention:

A. Help people get a doctor.

B. Help improve communications with medical assistants.

C. Provide more information about VD.

D. Provide information about the health aspects of pollution.

E. Help inform the public about chiropractic.

The Committee hopes that some of these plans will be approved this fall by The Council so that the 1973 MSMS budget can include necessary funds.

Committee on Rural Medical Service
Donald R. McCorvie, MD, *Chairman*

Rural Health Conference. The Committee met on April 12, 1972, and approved a proposal to co-sponsor a conference on rural health to be held in the spring of 1973. The conference will be co-sponsored by the committee, the Michigan Health Council and the Michigan State University College of Human Medicine. It will feature an opportunity for medical students, interns and residents to meet and discuss with physicians, hospital administrators and other health and community leaders the opportunities for rural practice.

Highway Signs to Hospitals with Emergency Departments. The Committee is pleased to report that the State Highway Department has agreed to place signs on major Michigan highways directing people to hospitals with emergency departments. The department is working out details and signs will be erected as soon as feasible.

Committee on Utilization Review and Health Insurance Problems

Robert C. Prophater, MD, *Chairman*

The Committee held meetings on January 19, 1972, February 24, 1972, and May 10, 1972.

Foundation. The Committee was assigned the responsibility of developing Articles of Incorporation and Bylaws for the proposed MSMS Foundation that was authorized by Resolution 100 of the 1970 House of Delegates.

Draft No. 8 of the Articles of Incorporation and Bylaws was approved by the House of Delegates at its Spring Meeting, and The Council was given the authority to establish the Foundation at its discretion.

Peer Review. In accordance with the "Guidelines for MSMS Peer Review Program," the Committee is now handling appeals from decisions of Regional Medical Advisory Committees and is holding liaison meetings with Michigan Medical Services to improve the present Blue Shield claim form.

17. Reports of House of Delegates Committees

Committee on Certificates of Commendation

Charles L. Oppy, MD, *Chairman*

The MSMS House of Delegates in 1961 established the MSMS Certificates of Commendation. The original action instructed that the awards "may include both scientific and/or public service, and may be awarded to one or several physicians annually who distinguish themselves in the medical profession."

The 1962 House of Delegates presented the first four such awards, and a number of awards have been recommended each year by committees and approved by the delegates.

This year, the Committee sent two invitations to each component county medical society inviting nominations. The Committee carefully evaluated 12 physicians, who had been recommended. The selection was most difficult.

The Committee is proud this year to present the names of five distinguished Michigan physicians for Certificates of Commendation. They are:

Lawrence G. Bateman, MD, of Flint
Dean C. Burns, MD, of Petoskey
Elisha S. Gurdjian, MD, of Detroit
Robert M. Nalbandian, MD, of Grand Rapids
Arthur L. Stanley, MD, of Lansing

Here are short biographies for your review:

LAWRENCE G. BATEMAN, MD

Lawrence G. Bateman, MD, a family physician in Flint for 40 years, was born February 21, 1907, in Duluth, Minnesota, and was graduated from the University of Michigan, receiving his BS in 1927 and his MD in 1931. He interned at Hurley Hospital in Flint. Throughout his long service to Flint families, he has exercised leadership in medical, religious and cultural affairs in his community. He has served as president of the Genesee County Medical Society and as a delegate to the Michigan State Medical Society and as chairman of virtually all of the county society's important committees. He has been president of the Genesee County Chapter of the Academy of Family Physicians. He has been a tireless and energetic worker for development of a Health Institute, now being constructed as an expansion of the Flint College and Cultural Center. For more than 20 years, Doctor Bateman has been an active member of the Finance Committee of Temple Beth El and a major fund raiser for the building of a new temple. He is past president of the Temple Beth El Brotherhood. Doctor Bateman is on the staffs of St. Joseph, McLaren General and Hurley Hospitals in Flint and is former chief of the medical staff at Hurley. He served as an army major, in command of a quartermaster corps medical detachment during World War II.

* * *

DEAN C. BURNS, MD

Dean C. Burns, MD, whose fame as a medical and community leader in Petoskey is almost a legend, was born there December 19, 1896, and was graduated from the University of Chicago in 1919 and from the Rush Medical College in Chicago in 1922. He served as an intern and as chief resident at St. Luke's Hospital in Chicago and completed post-graduate work in general surgery at Harvard and Columbia Universities. Doctor Burns' practice as a general surgeon spans 49 years. As founder of Burns Clinic, named in his honor, he has made available all specialities in medicine and surgery to the population of a large area of Northern Michigan. He also is the founder of the Burns Foundation which is dedicated to educational research. As chairman of the Board of Trustees of North Central Michigan College, he has contributed significantly to the growth of higher education and the establishment of a Nursing School at the college. Doctor Burns is director emeritus of Burns Clinic and a former chief of staff of Little Traverse Hospital, Petoskey. He is former president of the Northern Michigan Medical Society and the Michigan Association of Community College Trustees and served for six years as a member of the Michigan Coordinating Council for Public Higher Education. He is a member of the American College of Surgeons and the International College of Surgeons, as well as AMA and MSMS, and is a Fellow of the Royal Society of Health, Great Britain.

* * *

ELISHA S. GURDJIAN, MD

Elisha S. Gurdjian, MD, professor emeritus of neurosurgery at the Wayne State University School of Medicine, has a special interest in the dynamics of trauma and treatment of head injuries. He was born April 18, 1900, in Smyrna, Asia Minor, and was graduated from International College there in 1919. Later he received MS, PhD and MD degrees from the University of Michigan. He completed an internship and residency in neurosurgery at University Hospital in Ann Arbor and residency in general surgery at Rochester General Hospital. He has practiced as a neurosurgeon for 42 years. Doctor Gurdjian has served as chief of WSU neurosurgical services and as chief of staff of Grace Hospital. His academic affiliation with Wayne State began in 1939 and he has been chairman of the Department of Neurosurgery in the School of Medicine as well as professor of neurosurgery, engineering mechanics, in the WSU College of Engineering and director of the WSU Biomechanics Research Center. He is devoting much of his time today to research into the dynamics of trauma and treatment of head injuries. He has published four scientific books. Earlier this year he was selected to present the Beaumont Lecture for the Wayne County Medical Society. Doctor Gurdjian is a member of the Head Injuries Committee of the World Federation of Neurosurgical Societies, a former chairman of the Section of Nervous and Mental Diseases of the AMA, a member of the American Associations of Neurological Surgeons, Anatomists and University Professors; former chairman, Advisory Council for Neurosurgery, American College of Surgeons; former vice-chairman of the American Board of Neurological Surgery, former vice president of the American Neurological Association, and a member of numerous other medical organizations.

* * *

ROBERT M. NALBANDIAN, MD

An internationally known researcher into sickle cell anemia, Robert M. Nalbandian, MD, associate pathologist at Blodgett Memorial Hospital, Grand Rapids, and adjunct associate professor of physiology at the Wayne State University School of Medicine, was born August 4, 1922, in Detroit. He received his BA and MD degrees from Wayne State. He completed a residency in pathology at WSU Affiliated Hospitals and a residency in surgery at Harper Hospital, Detroit. Doctor Nalbandian was affiliated with Detroit area hospitals before going to Grand Rapids in 1968. He is a consultant to Deaconess and Children's Hospitals in Milwaukee. He is a member of the American Society of Clinical Pathologists, the College of American Pathologists, the Detroit Physiological Society, the Michigan Society of Pathologists, the Association of Clinical Scientists, the International Academy of Pathologists, the Pan-American Medical Association, the New York Academy of Sciences and the Reticulo-Endothelial Society as well as county and state medical societies and the AMA.

Doctor Nalbandian is noted for his work in the development of screening and treatment programs for sickle cell anemia and last May received one of the first Doctor Martin Luther King, Jr., Medical Achievement Awards for this work from the Southern Christian Leadership Conference. He has made many contributions to the field of medical literature.

* * *

ARTHUR L. STANLEY, MD

Arthur L. Stanley, MD, was born October 28, 1907 in Freesoil, a small town in western Michigan, and as a small boy he longed to become a physician. He was graduated from Michigan State College in 1934 and received his MD degree from the University of Michigan in 1938. He interned at Hurley Hospital in Flint and completed residencies at Pontiac General Hospital and Ingham Medical Hospital, Lansing, where he has practiced as a thoracic surgeon since 1946. He is medical director of Ingham Medical Hospital, where a wing was named in his honor in 1965. He serves as a consultant in thoracic surgery at Sparrow and St. Lawrence Hospitals, also in Lansing. He is a Fellow of the American College of Chest Physicians and the American College of Surgeons and belongs to the Society of Thoracic Surgeons, the Michigan Thoracic Society and the American Trudeau Society, as well as the AMA and state and county medical societies. A tuberculosis victim himself, Doctor Stanley has been a leader in providing improved treatment for persons suffering from respiratory ailments.

He established residency training for thoracic surgeons here in 1952 and in 1966 performed the first open heart surgery in the Lansing area. His leadership has resulted in the establishment of the Ingham Medical and St. Lawrence Hospital Mental Health Centers along with Beekman and Lincoln Centers. For many years he has been a leader in the Michigan Tuberculosis and Respiratory Disease Association.

MSMS Certificates of Commendation have been presented by the MSMS House of Delegates to the following distinguished physicians since the award was originated in 1961:

1962 J. W. Conn, MD, Ann Arbor
G. D. Cummings, MD, Lansing
C. S. Kennedy, MD, Detroit
R. L. Novy, MD, Detroit

1963 F. D. Dodrell, MD, Bloomfield Hills
C. J. Jentgen, MD, Detroit
J. M. Sheldon, MD, Ann Arbor
H. H. Stryker, MD, Kalamazoo
1964 Goldie Corneliuson, MD, Lansing
J. S. DeTar, MD, Milan
R. M. Heavenrich, MD, Saginaw
N. F. Miller, MD, Ann Arbor
E. G. Upjohn, MD, Kalamazoo
O. R. Yoder, MD, Ypsilanti
1965 F. J. Hodges, MD, Ann Arbor
T. Leucutia, MD, Detroit
R. J. Robinson, MD, Detroit
1966 A. C. Curtis, MD, Ann Arbor
L. L. Davis, MD, Mt. Pleasant
Mark Marshall, MD, Ann Arbor
H. J. Meier, MD, Coldwater
R. H. Pino, MD, Detroit
A. B. Swanson, MD, Grand Rapids
H. A. Towsley, MD, Ann Arbor
1967 F. J. Busch, MD, Saginaw
W. H. Huron, MD, Iron Mountain
F. J. Margolis, MD, Kalamazoo
D. I. Sugar, MD, Detroit (posthumously)
R. W. Waggoner, MD, Ann Arbor
C. H. Wright, MD, Detroit
1968 A. F. Barbour, MD, Flint
H. L. Clark, MD, Ludington
J. M. Dorsey, MD, Detroit
F. C. Sabin, MD, Marquette
W. D. Towsley, MD, Midland
1969 H. A. Furlong, MD, Pontiac
W. W. Jack, MD, Grand Rapids
A. C. Kerlikowske, MD, Ann Arbor
R. C. Prophater, MD, Bay City
A. L. Tuuri, MD, Flint
C. M. Vasu, MD, Grand Rapids
1970 H. E. Branch, MD, Flint
M. Clapper, MD, Detroit
H. F. Falls, MD, Ann Arbor
H. W. Harris, MD, Lansing
R. E. Rice, MD, Greenville
Sarah Schooten, MD, Detroit
1971 Eugene R. Elzinga, MD, Marquette
Tommy N. Evans, MD, Detroit
John V. Fopeano, MD, Kalamazoo
Leland E. Holly, Sr., MD, Muskegon
James M. Kennary, Sr., MD, Detroit
Lionel F. Swan, MD, Detroit

THE HOUSE, acting as a committee of the whole, approved the report of the Committee. Subsequently, at the Tuesday evening banquet, Certificates of Commendation were presented to Doctors Bateman, Burns, Gurdjian, Nalbandian, and Stanley.

Report of Ad Hoc Task Force on Continuing Medical Education

Robert J. Mason, MD, *Chairman*

Resolution 7 of 1971 contains the following House of Delegates directive:

> "RESOLVED: That this House of Delegates instruct the Speaker to appoint an ad hoc task force to review the proposal submitted by the Postgraduate Education Committee, and be it further
>
> RESOLVED: That this ad hoc task force undertake to revise or modify that proposal as it deems appropriate and submit a detailed series of final recommendations for consideration by the 1972 House of Delegates."

The Postgraduate Education Committee proposal referred to in the Resolution contained the following recommendation:

> "That every five years each physician practicing in Michigan, as a requirement for maintenance of his license to practice medicine, would have to provide evidence of the fact that he met certain minimal requirements of certain postgraduate continuing programs (patterned after a modification of the California requirements)."

In order to competently deal with the issue, the Task Force has studied a great variety of materials on the subject of continuing medical education. We have studied various programs with a continuing medical education requirement for state society membership and for state relicensure. We also considered programs voluntary in nature patterned after that of the American Medical Association. In addition, the committee reviewed a number of articles written by members of the profession, the public, and the press on the issue of continuing education for physicians.

Throughout the deliberations of the Task Force, certain key themes regarding a philosophical approach to continuing medical education were repeated which form the basis of our final recommendations. In order to share with you the development of our thoughts, your Task Force wishes to reiterate its major considerations.

1. There is general agreement among physicians that there is a definite need to encourage continuing medical education for physicians to maintain their professional modernization.
2. Any program of continuing medical education should include all Michigan physicians and not be limited to MSMS members.
3. The establishment of any standards for physicians in continuing education is the sole responsibility of the medical profession and not of any governmental unit.
4. While mere attendance at postgraduate programs does not assure education of increased competence, yet when compared to complex proposals such as record audit, or other techniques to review quality of patient care, actual attendance at meetings is the most practical measure of continued education at this time.
5. Before any program is adopted, much time and effort should be devoted to developing effective accreditation procedures for programs, identifying problems with existing programs, and leading to the elevation of the general quality of programs available to physicians in this state.
6. Any program of continuing education should also include such activities as teaching, personal reading and study, writing, informal discussions, use of audio-visual aids, as well as participation in formal educational experiences.
7. Any program should be in a form of gradual acceleration and review to insure an increased elevation of continuing education and patient care.
8. Voluntary programs, while the most desirable and acceptable to physicians, do not contain the necessary incentives to reach those physicians who need continuing education the most.

In general, your Task Force believes that a program of continuing medical education should not be regarded as a new form of training, but rather as a plan for organizing and recognizing existing experiences in order to provide (1) better coordination of and participation in continuing education and (2) proper professional and public recognition of the physician's participation.

The directive to this Task Force specified that we review the question of a continuing education requirement for licensure and make specific recommendations on that issue to the House of Delegates. In compliance with that directive, we have restricted our deliberations and have not developed a complete mechanism for implementation of our recommendations. We believe that such subsequent implementation merits the creation of a permanent commission which will also have the responsibility of periodic review and gradual acceleration of the system to be established.

Therefore, the Ad Hoc Task Force on Continuing Medical Education unanimously recommends the following to the House of Delegates:

1. That an appropriate commission of the Michigan State Medical Society be created and empowered to

develop a flexible series of minimal continuing medical education standards for physicians practicing in Michigan.

2. That such standards be based on a broad approach requiring a set number of credits using facilities and approved programs of hospitals; medical schools, county, state and national societies, and other current and developing methods of continuing educacation as determined by the permanent commission.
3. That the Michigan State Medical Society establish basic principles of approval for all continuing medical education programs in the State of Michigan and also guidelines for reciprocity with accredited programs of other state, regional and national organizations.
4. That the Michigan State Medical Society recommend to the State Board of Registration in Medicine that, prior to re-registration each third year, a physician shall meet one of the following personally selected criteria:
    (a) He may write a special relicensure examination, if he so chooses; or
    (b) He may show evidence of continued competence by means of certification by an approved patient care review organization or national specialty societies; or
    (c) He may submit evidence that he has met the MSMS continuing education requirements by documentation of participation in formal educational activities (including use of facilities and approved programs of hospitals; medical schools; county, state, and national societies) as well as participation in informal educational experiences (including teaching, personal reading and study, writing, informal discussions and use of audio-visual aids).

REFERENCE COMMITTEE C recommended approval of Recommendations 1, 2, and 3 and disapproval of Recommendation 4.

THE HOUSE adopted the report of the Committee.

Committee on Constitution and Bylaws
STUART M. GOULD, JR., MD, *Chairman*

The following Bylaws changes were passed on first reading by the House of Delegates at the Spring 1972 meeting and are herewith presented for final approval.

Seating and Tenure of Delegates

Change Chapter 9, Sec. 4 to read:

Sec. 4 SEATING—TENURE. A delegate, or in his absence, an alternate delegate (in order of seniority) becomes a member of the House of Delegates when duly registered and seated at the first scheduled regular session following certification by the component society, specialty section or SAMA chapter, and remains a delegate until the expiration of his term."

Explanation: The words "specialty section or SAMA chapter" were added subsequent to the Spring House meeting so that provisions for component societies, specialty and SAMA groups would be uniform. However, the Committee does not believe that these are substantive changes, and believes that the House can now take final action on this proposed amendment.

House of Delegates Meetings

Change Chapter 9, Sec. 6 to read:

"Sec. 6. MEETINGS—ANNUAL SESSION—The House of Delegates shall meet at least annually at the time and place . . . . etc."

THE HOUSE adopted the foregoing amendments on final reading.

Establishment of an Office of Vice President

At the Fall 1971 meeting of the House, the Committee was authorized to study the possibility of establishment of the office of Vice President, for the sole purpose of succeeding to the Presidency should the President become disabled before taking office. The House also requested the Committee to study other possibilities for succession in such an instance. The Committee would like to continue its deliberations on this matter and present definitive recommendations at a later date.

Composition of Constitution and Bylaws Committee

The Speaker has concurred in the suggestion of the reference committee last year that there was merit in having the Standing Committee on Constitution and Bylaws also serve as the Reference Committee on Constitution and Bylaws during meetings of the House. This will provide for continuity whereby a group of people who are knowledgeable and familiar with the MSMS Constitution and Bylaws will be the group considering all matters having to do with that document. Thus they will be able to provide ongoing guidance in possible improvements.

It is our recommendation to the House of Delegates that the Speaker be instructed to appoint this Committee annually immediately following the annual meeting of the House of Delegates, to serve during the subsequent year through the next annual meeting, and that it be composed of seven members of the House of Delegates, with the MSMS Legal Counsel and Director as ex officio members without vote. The Committee will constantly study the Constitution and Bylaws and recommend revisions and modifications necessitated by changing times, methods or conditions. All proposals for amendments to the Constitution and Bylaws, wherever possible, should be substituted to this Committee in advance by any person suggesting such proposals, for the Committee's consultation and advice. This action does not require a change in the Bylaws.

Reference Committees of the House of Delegates

In order to conform to present practices, the Committee recommends that Chapter 9—House of Delegates, Sec. 9—Reference Committees be amended to read:

"Sec. 9. Reference Committees. The House of Delegates shall have the following reference committees, together with tellers and sergeant-at-arms, appointed by the Speaker of the House, and such other reference committees as the Speaker may deem necessary to conduct the business of the House:

1. Credentials
2. Rules and Order of Business
3. Constitution and Bylaws (which shall serve also as the standing committee on Constitution and Bylaws)
4. Ways and Means

Membership

It has been brought to the Committee's attention that the system for partial dues payments and dues refunds has become somewhat cumbersome over the years and that it would be advantageous to streamline this procedure and change some of its provisions. The Committee agreed to study this section re partial dues payment during the coming year.

The current provision for refund of dues due to death or expulsion is a cumbersome matter. A survey of other state medical associations shows that none have this provision.

The refund complicates the estate since it has already been declared a tax deduction and the amount of money involved is insignificant.

Therefore we recommend That Chapter 4, Sec. 4, which provides for refunds for death or expulsion, be deleted.

Reference Committees of The Council

During the past two years The Council has made, with the permission of the House, some changes in The Council reference committee system. It was agreed that this would be done on a trial basis and that, if it proved successful, Bylaws changes would be recommended to make these changes permanent. We are now making specific recommendations to change the Bylaws to reflect these changes.

Therefore the Committee recommends the following changes:

1. Amend the last sentence of Chapter 10, Sec. 1, as follows:

   "At its first meeting following the Annual Session of the House of Delegates, it shall elect a Chairman, a Vice-Chairman, a Chairman of the Finance Committee, a Chairman of the Scientific and Educational Affairs Committee, and a Chairman of the Legislative Policy Committee, who shall be duly elected Councilors, each to take office immediately and to serve for a term of one year or until his successor is elected and takes office."

2. Amend Chapter 10, Sec. 2, as follows:

   "Sec. 2. EXECUTIVE COMMITTEE—The Executive Committee of The Council shall consist of the President, the President-Elect, the Speaker of the House of Delegates, the Vice-Speaker of the House of Delegates, the Chairman of The Council, the Vice-Chairman of The Council, the Secretary, the Treasurer, the Chairman of the Finance Committee, the Chairman of the Scientific and Educational Affairs Committee, and the Chairman of the Legislative Policy Committee. The Chairman of The Council shall serve as Chairman of the Executive Committee."

3. Amend Chapter 10, Sec. 3, as follows:

   "Sec. 3. REFERENCE COMMITTEES—The Reference Committees of The Council and their composition and duties shall be as follows:

   (a) The Scientific and Educational Affairs Committee shall consist of a Chairman elected by The Council as provided above and members appointed by the Chairman of The Council with the advice and approval of The Council. The Scientific and Educational Affairs Committee shall advise The Council on matters of scientific and educational activity and relationships with component medical societies, and consider other matters referred to it by The Council.

   (b) The Finance Committee shall consist of a Chairman elected by The Council as provided above and members, of which one shall be The Treasurer, Ex Officio, with power to vote, and the remainder appointed by the Chairman of The Council with the advice and approval of The Council. The Finance Committee shall advise The Council on administration of the Society's finances, and consider other matters referred to it by The Council.

   (c) The Legislative Policy Committee shall consist of a Chairman elected by The Council as provided above and members. The Legislative Policy Committee shall advise The Council on matters of legislation and liaison with governmental agencies and shall consider other matters referred to it by The Council.

   Sections (d) and (e) of Sec. 3 are to be deleted.

4. Amend Sec. 4, Chapter 10, as follows:

   "Sec. 4 SPECIAL AND AD HOC COMMITTEES—The following committees shall be appointed by The Council or its Chairman, with the advice and approval of The Council:

   (a) The Publication Committee shall serve as the Editorial Board of the Journal of the Michigan State Medical Society and shall advise The Council and the Executive Editor in the conduct and policy of the Journal. The Scientific Editor shall be an ex officio member of This Committee, without power to vote.

   (b) The Education Committee shall consist of a Chairman, and not more than seven members. The deans of the medical schools of Michigan and the Secretary of the Michigan State Board of Registration in medicine shall be advisory members of this committee without power to vote. The Education Liaison Committee shall advise The Council on matters pertaining to undergraduate medical education.

   (c) Such additional special and ad hoc committees may be appointed as may be required to administer efficiently the functions and duties of The Council, provided that no existing standing or special committee is qualified to perform such duties. Each such committee shall be required to render periodic reports to The Council of its activities, findings and recommendations.

Committee Plans for 1972-73

In addition to considering the foregoing items, the Committee during the coming year will study several recommendations for bylaws revision in the following areas:

1. Membership Classification, Dues System, and Sections. The Committee will consider changes in the number of dues classification, further simplification in dues reporting, making provision for student, resident and intern membership, and establishment of a section on academic medicine. These latter two items were recommended by Council Chairman Masters at the spring meeting of the House.
2. Committees. The Planning and Priorities Committee has been working on streamlining these committees and will have further recommendations along these lines. The Constitution and Bylaws Committee will attempt to amend and clarify the bylaws provisions regarding committees to reflect these and other appropriate changes.
3. As indicated at the beginning of this report, the Committee will have an ongoing review of the entire Constitution and Bylaws to make sure that its provisions reflect the actual procedures which are now in effect, and to bring to the attention of the House of Delegates those areas where further consideration is required.
4. Vice-Presidential study.
5. Study of the duties of the Secretary.

THE HOUSE approved the recommendations of the Constitution and Bylaws Committee, laying over to the 1973 Spring Session those amendments which were presented on first reading.

RESOLUTIONS

• RESOLUTION 72A-1

Control of Promotion and Sale
of Medical and Disability Insurance Policies
Clifford W. Colwell, MD, Genesee County

House Action: Adopted as Amended

Whereas, there is national concern over the cost and methods of financing health care, and

Whereas, it is recognized by all responsible authorities that limited coverage and/or fragmented policies of medical or disability insurance are expensive and generally undesirable, and

Whereas, public hearings and the news media have attempted to publicize the pitfalls and high cost of such insurance but without significantly altering the promotion of this insurance by various companies, and

Whereas, other states have enacted legislation so that insurance commissioners have been able to prohibit the promotion and sale of such policies when not in the public interest, now, therefore be it

RESOLVED: That the Michigan State Medical Society affirm its opposition to the promotion and sale of medical and/or disability insurance policies which are restricted in coverage and broad in exclusionary devices, and be it further

RESOLVED: That the Michigan State Medical Society urge the Michigan Legislature to enact appropriate legislation which will permit the State Commissioner of Insurance to prohibit the promotion and sale of such policies.

● RESOLUTION 72A-2

Physician Service in Outpatient Departments
Ralph Cooper, MD, Wayne County

House Action: Amended and referred to the Judicial Commission

Whereas, many of the patients in medical outpatient departments are now paid for by third party carriers; and

Whereas, some hospitals are now requiring attending staff members to care for patients in the outpatient departments as a requirement of staff membership; and

Whereas, the Judicial Council of the American Medical Association has ruled that mandatory financial contribution as a condition of staff membership is unethical; therefore be it

RESOLVED: That the Michigan State Medical Society declare that it is unethical to require physicians to take care of patients in the outpatient department as a requirement for staff privileges when services are paid to the hospital either by the patient or a third party carrier, and be it further

RESOLVED: That a resolution be submitted by the Michigan delegates to the AMA at its 1972 Clinical Session recommending that the American Medical Association adopt a similar ruling.

● RESOLUTION 72A-3

The Defense of Physicians by the Michigan State Medical Society
Charles Darling, MD, Wayne County

House Action: Adopted as Amended

Whereas, the Michigan State Medical Society in its 1971 House of Delegates adopted Resolution 25 titled, "The Defense of Physicians by the Michigan State Medical Society," and

Whereas, there has been little publicity of the directives of Resolution 25 (see below), therefore be it

RESOLVED: That The Council of the Michigan State Medical Society be directed to implement Resolution 25 of the 1971 House of Delegates of the Michigan State Medical Society in 1972; and be it further

RESOLVED: That the staff of the Michigan State Medical Society be directed to publicize the contents of Resolution 25.

> **1971 Resolution 25—"Defense of Physician by Michigan State Medical Society"**
>
> **Whereas,** Michigan Medical Service (Blue Shield) has sent to its subscribers letters indicating it would defend such subscriber in any action that a non-participating physician might take to recover his fee for service rendered the subscriber, if Blue Shield deems the fee excessive and
>
> **Whereas,** such action on Blue Shield's part is considered to be arbitrary and detrimental to the usual patient-physician relationship, and therefore be it
>
> **RESOLVED:** That the Michigan State Medical Society through Peer Review mechanisms, shall review and, if indicated support the physician in any action in which a third party participates to prevent the physician from obtaining his usual fee, provided the case has been reviewed and the physician supported by his local peer review committees.

● RESOLUTION 72A-4

Blue Shield Profiles
Alexander Blain, III, MD, Wayne County

House Action: Disapproved

Whereas, the Blue Shield method of establishing physicians' profiles is discriminatory and unjustified; and

Whereas, new physicians entering practice set their fees at the maximum level and obtain high profiles; and

Whereas, experienced physicians whose fees were modest have profiles which are unreasonably low and are reimbursed at a minimum level; therefore be it

RESOLVED: That the Michigan State Medical Society insist that Blue Shield abandon its present method of setting physicians' profiles; and be it further

RESOLVED: That a new method be devised whereby each physician may set his own profile of fees in accordance with his training and years of experience and subject to review by the appropriate committee of his county medical society on request of Blue Shield.

● RESOLUTION 72A-5

Prospective Payment to Subscribers
Benjamin Jeffries, MD, Wayne County

House Action: Disapproved

Whereas, the physicians of Michigan, by their establishment in 1939 of the Blue Shield Service Benefit Concept, and their majority support and participation in the program since have demonstrated the soundness of the service benefit concepts, and

Whereas, the citizens of Michigan in an acceptance of this program that has made it the major health insurer of the State, have demonstrated their desire for a service-benefit program, and

Whereas, prospective payment for medical service has been advocated and in some instances insisted upon by third parties, therefore be it

RESOLVED: That The Council of Michigan State Medical Society be empowered at its option, to call upon, and advise its physician membership to require a prospective deposit of the insured of any plan, at least equal to ninety (90) per cent of the estimated customary fee for elective, non-emergent medical services, and be it further

RESOLVED: That The Council shall advise its membership that any draft issued by third parties for such prospective payments be drawn payable only to the subscriber, and be it further

RESOLVED: That the physicians shall provide the subscriber with no more than the information required on the proposed "simplified claim form" for presentation to his insurer for prospective payment.

● RESOLUTION 72A-6

Maternal and Child Health Committee
Benjamin Jeffries, MD, Wayne County

House Action: No Action

Whereas, there is an increasing amount of research to indicate that the influences on the health of the infant begin even before conception, and include maternal influences during gestation as they act on the embyro, the fetus, the neonate and the infant is continuum; and

Whereas, recent Senate hearings of the Senate Subcommittee on Children and Youth is directing the National Institute of Child Health and Human Development of the Department of Health, Education and Welfare to give this entity a high priority; therefore be it

RESOLVED: That the Maternal and Perinatal Health Committee should include and become more thoroughly involved with the problem of "Crib Deaths" or the Sudden Infant Death Syndrome and that the name of the Committee be changed to the **Maternal and Child Health Committee** to reflect the added concern.

● RESOLUTION 72A-7

A Councilor for Oakland County
Edward E. Elder, Jr., MD, Oakland County

House Action: Withdrawn

Whereas, Oakland County Medical Society now has 757 members; and

Whereas, Oakland County now has 15 delegates to the Michigan State Medical Society, and

Whereas, Oakland County does not have a member on The Council of Michigan State Medical Society; therefore be it

RESOLVED: That this session of the Michigan State Medical Society House of Delegates take the necessary steps to have Oakland County adequately represented on The Council by one of two means:

A. Elect two (2) Councilors from the present 15th Councilor District, or

B. Rearrange the boundaries of the Councilor Districts to give Oakland County more adequate representation.

● RESOLUTION 72A-8

Change in Prescription for Ritalin

Edward E. Elder, Jr., MD, Oakland County

House Action: Following Substitute Resolution Adopted as Amended in lieu of Resolution 72A-8.

Whereas, many physicians throughout the United States use the medicine, methylphenidate HCl (Ritalin) daily in their practices; and

Whereas, the incidence of dependence, chronic overdosage and misuse of this medicine is very low; and

Whereas, present United States government regulations have placed this medicine on the most restricted dangerous drug list prohibiting refills; therefore be it

RESOLVED: That Michigan State Medical Society investigate the feasibility of removing Ritalin from the dangerous drug list, and be it further

RESOLVED: That MSMS seek all means to restrain the FDA and other agencies from making further restrictions on prescribing drugs while ignoring expert medical opinion.

● RESOLUTION 72A-9

Selection of MDs for paramedical college instructors

Thomas J. Setter, MD, Macomb County

House Action: Adopted as Amended

Whereas, Michigan universities, colleges, community colleges and some community agencies are providing more and more credit and noncredit courses for medical and paramedical personnel and for the general public about health and medicine, therefore be it

RESOLVED: That the Michigan State Medical Society offer each Michigan university, college, community college and known sponsor of health credit and non-credit courses its good offices in obtaining qualified instructors.

● RESOLUTION 72A-10

Signing Medicaid Provider Agreement of Dept. of Social Services

Edward R. Weddon, MD, Jackson County

House Action: Following Substitute Resolution Adopted as Amended in lieu of Res. 72A-10 and the Recommendation of The Council.

Whereas, physicians in Michigan traditionally have and will continue to provide medical care to patients regardless of third party carriers, and

Whereas, significant issues between MSMS and the Michigan Department of Social Services remain unresolved, and

Whereas, the federal requirement of signing an agreement allows this to be done on an individual case basis; and

Whereas, it has been a fundamental principle of the traditional doctor-patient relationship that billings have been on a per case basis rather than by a broad Provider Agreement, therefore be it

RESOLVED: That the Michigan State Medical Society advise its members not to sign the broad Provider Agreement, and be it further

RESOLVED: That members of MSMS who have already signed a participating agreement be urged to resign unless it would result in personal hardship to the physician or his patients.

● RESOLUTION 72A-11

House of Delegates Seat for Medical School Deans

Jack Stack, MD, Gratiot County

House Action: Referred to the Constitution & Bylaws Committee with request that the Committee report to the House at the 1973 Spring Meeting

Whereas, the Michigan State Medical Society has expressed a continuing interest in the medical education in our medical schools, and

Whereas, direct communication with leadership of the medical schools would be better served by active participation by the Deans of the Medical Schools in the House of Delegates of the Michigan State Medical Society; therefore be it

RESOLVED: That the Deans of each medical school in Michigan shall have a seat in the House of Delegates of MSMS, if a member of the Michigan State Medical Society.

● RESOLUTION 72A-12

Separate County Chapter Status for Gratiot County

Jack Stack, MD, Gratiot County

House Action: Adopted

Whereas, the majority of physicians of Gratiot County have petitioned MSMS for separate status as a County Medical Society, and

Whereas, The Council of MSMS has taken no action on the request for a separate charter to Gratiot County, and

Whereas, MSMS must respond to changing patterns of practice and the relevancy of MSMS to physicians in the communities; therefore be it

RESOLVED: That the House of Delegates authorize that a separate charter be issued to the Gratiot County Medical Society and a separate charter to Isabella-Clare County Medical Society prior to January 1, 1973.

● RESOLUTION 72A-13

Rehabilitative Care and Legislation

Harvey M. Andre, MD, Kent County

House Action: Adopted

Whereas, there is an increasing number of chronically ill and disabled patients in our population, and

Whereas, it is this group whose health care has been relatively under-financed as compared to those suffering acute care and episodic illness, and

Whereas, the most effective efforts on behalf of the chronically ill and disabled are those embodied in a comprehensive rehabilitation program, and

Whereas, the medical profession is and must be intimately involved in the rehabilitation process, and

Whereas, proposed federal health legislation does not adequately spell out rehabilitation benefits, therefore be it

RESOLVED: That the Michigan State Medical Society actively support and encourage enactment of appropriately worded federal legislation to provide rehabilitative care for the chronically ill and disabled patients to restore them to optimal physical, mental, social, vocational, and economic usefulness, these needs to be determined by trained medical doctors and not laymen, and be it further

RESOLVED: That The Council of Michigan State Medical Society seek active support for this type legislation from other state medical societies, and be it further

RESOLVED: That Michigan State Medical Society delegates to American Medical Association be instructed to sponsor a resolution in the American Medical Association House of Delegates supporting this concept of rehabilitative aid, to provide adequate dollars for the proper care of the chronically ill and disabled.

● RESOLUTION 72A-14

Establishment of a uniform fee schedule for all insurance carriers, Medicaid, Medicare and Social Welfare Departments throughout the State of Michigan
Herbert L. Nigg, MD, Tuscola County

House Action: Disapproved

Whereas, the fees established by Blue Shield vary throughout the state according to geographical location as much as and possibly more than 35 percent, and

Whereas, third parties such as Aetna, Medicaid, Medicare, Social Welfare and others, have increased the physician's dependence upon third parties for payment, and

Whereas, these third parties use the old profile system for the establishment of their fees and an almost routine basis for the further reduction of fees, and

Whereas, this grossly discriminatory procedure effectively deters the settlement of new physicians in the very area where they are most needed and is detrimental to those who have previously established practices in these areas; therefore be it

RESOLVED: That the Michigan State Medical Society protect this minority group of physicians by establishing a uniform fee system, and be it further

RESOLVED: That the Michigan Relative Value Scale be used as a basis for payment throughout the state, and be it further

RESOLVED: That adjustments in the scale be made known to all members of the Michigan State Medical Society.

● RESOLUTION 72A-15

The Michigan Abortion Referendum
Jack Stack, MD, Gratiot County

House Action: Adopted as Amended

Whereas, the Michigan Abortion Referendum gives the people of Michigan an opportunity to resolve the question of medical control of abortion; and

Whereas, the proposal states, "Any other laws to the contrary notwithstanding, a licensed medical or osteopathic physician may perform an abortion at the request of a patient, if the period of gestation has not exceeded 20 weeks. The procedure shall be performed in a licensed hospital or other facility approved by the Department of Public Health," and

Whereas, the Michigan State Medical Society recognizes that some individual physicians are personally opposed to abortion, and

Whereas, the Michigan State Medical Society endorsed the petition drive in 1971 to place this issue in the ballot; and

Whereas, the Michigan State Medical Society believes that passage of the Michigan Abortion Referendum is in the best interest of the health and welfare of the people of the State of Michigan; therefore be it

RESOLVED: That the Michigan State Medical Society endorse the passage of the Michigan Abortion Referendum, and be it further

RESOLVED: That the policy of the Michigan State Medical Society on abortion be consistent with the proposed law that a licensed medical or osteopathic physician may perform an abortion at the request of a patient, if the period of gestation has not exceeded 20 weeks and that this procedure shall be performed in a licensed hospital or other facility approved by the Department of Public Health; and be it further

RESOLVED: That the abortion not be performed until counseling be done.

● RESOLUTION 72A-16

Early Submission of Resolutions
Jack Stack, MD, Gratiot County

House Action: Disapproved

Whereas, it is a real bother to work to prepare resolutions prior to Labor Day, and

Whereas, the Spring 1972 House of Delegates passed a resolution which requires presentation 30 days prior to meeting, and

Whereas, because most component societies do not meet in the summer, opportunities for development of resolutions are minimal prior to the House of Delegates, and

Whereas, it's darn hard to get this work done anytime, and

Whereas, 15 days would be very adequate time for the processing of resolutions, therefore be it

RESOLVED: That resolutions shall be submitted to MSMS 15 days prior to the meeting of the House of Delegates, and be it further

RESOLVED: That the Speaker of the House of Delegates may allow resolutions to be presented in the first session of the House, and be it further

RESOLVED: That resolutions may be presented in the first session of the House by consent of a simple majority of members present and voting.

● RESOLUTION 72A-17

Negotiations with Third Parties
Marion McCall, MD, Wayne County

House Action: Disapproved

Whereas, government and other third parties are becoming a primary source of payment for patient benefits, and

Whereas, the physicians are perceived by fiscal agents as a class rather than as individuals, and

Whereas, between sessions of the House of Delegates it is the responsibility of The Council of Michigan State Medical Society to advise the profession and public relative to medical care programs, therefore be it

RESOLVED: That the official representatives of The Council be instructed to report to The Council on any proposed agreement with third parties which will provide medical services and which will require participation by physicians; in turn The Council be requested to report fully to the membership.

● RESOLUTION 72A-18

Consent by Staff Patients
Ralph Cooper, MD, Wayne County

House Action: Adopted as Amended

Whereas, these patients on applying for care at the hospital outpatient department or emergency room are occasionally assigned to staff services without knowledge of their right; therefore be it

RESOLVED: That patients who seek service in the hospital outpatient department or the emergency room be advised of their right to private medical care and the availability of such care.

● RESOLUTION 72A-19

Exploitation of Physicians
Donald Bryan, MD, Wayne County

House Action: Referred to the Judicial Commission of MSMS

Whereas, "Employed physicians" are assuming an increasing and prominent role in medical practice; and

Whereas, changes in structure of health care financing, and changes in the organization of health care delivery are contemplated, with employed physicians assuming an even more important part of these structures; and

Whereas, Judicial Opinions and Reports of the American Medical Association, Sections 6 and 7, proscribe the sale of medical services to a direct profit of a lay group; proscribes the disposal of a physician's services to any hospital, corporation, or lay group by whatever name which permits the sale of the services of that physician and prohibits the unethical division of fees between physicians; therefore be it

RESOLVED: That the Michigan State Medical Society declare as unethical the exploitation of physicians and physicians services for profit; regardless of the type or structure of the employing organization, whether lay or professional and whether a profit making or non-profit organization; profit is herein defined as assets accrued in providing professional services in excess of a reasonable overhead necessitated in the providing of such service; and be it further

RESOLVED: That this resolution apply to all members of the MSMS whether their positions are of employer or employee; and be it further

RESOLVED: That a resolution be submitted by the Michigan Delegates to the American Medical Association at its 1972 Clinical Session recommending that the American Medical Association adopt a similar ruling.

● RESOLUTION 72A-20

Manual for Medicaid Recipients
Kenneth Ray, MD, Wayne County

House Action: Adopted as Amended

Whereas, many Medicaid recipients are not knowledgeable about the benefits and exclusions of the Medicaid program, and

Whereas, this lack of information may create physician-patient misunderstandings; and

Whereas, the burden of explaining the Medicaid program should not be placed upon busy practitioners; therefore be it

RESOLVED: That The Council of MSMS urge the Department of Social Services to publish and distribute a manual outlining clearly the benefits and exclusions of the Medicaid program, and that Michigan State Medical Society offers its advice in the preparation of such a manual.

● RESOLUTION 72A-21

The Participation of Physicians in Third Party Health Insurance Schemes
Wayne County Medical Society, Marion McCall, MD, Wayne County

House Action: Disapproved

Whereas, in the matter of third-party health-insured plans, an informed carrier, and an informed provider can only result in a better and more effective public service, and

Whereas, the presently used system of defining participation of providers in these schemes has been a glaring source of nearly all the confusion and conflict in these programs, and

Whereas, an alternative, defined participation agreement can very likely resolve all but the philosophical objections to participation, therefore be it

RESOLVED: That the physicians of Michigan do require an alternative participation agreement from Medicaid and any third party that presume to provide service benefits, and be it further

RESOLVED: That physicians of Michigan do require that any agreement bear the prior endorsement of The Council of the Michigan State Medical Society, and be it further

RESOLVED: That the physicians of Michigan do require that said agreement will include at a minimum provision for:

a) A simplified claim procedure.
b) A provision for timely payment and penalty for less than timely payment.
c) A provision for timely notification to physicians of the third party's perception of the physicians' individual customary fee and a mechanism of resolving any disputes.
d) A definite time limit on the agreement, with a statewide expiration date.
e) A defined method of resolution of any individual case and general disputes between physician and intermediary.
f) A recognition that the Physician Manual constitutes an integral part of this agreement and is not subject to unilateral alteration or interpretation.
g) For proportional provision of basic liability coverage for a participating physician.
h) An effective date of November 1, 1972.

● RESOLUTION 72A-22

To Assist our Patients in the Distribution of their Health Insurance Dollar
Marion McCall, MD, Wayne County

House Action: Following Substitute Resolution Adopted in lieu of Resolution 72A-22.

Whereas, the complexities of benefits versus costs in modern health insurance contracts impose an impossible burden upon our patients in comparing health insurance policies, and

Whereas, the increasing complexity and sophistication of medical care, with consequent rising cost, make fixed benefit health insurance policies obsolete in a relatively few years, and

Whereas, no method exists to inform our patients of the extent of this obsolescence, therefore be it

RESOLVED: That the MSMS Bureau of Economic Information be directed to obtain annually a cost and benefit comparison of various health insurance plans available in Michigan, and be it further

RESOLVED: That this information, when available, be distributed to physicians of Michigan and upon request, to other interested parties.

● RESOLUTION 72A-23

Blue Cross Reimbursement for Medical Coverage in Hospitals
Alexander Blain, III, MD, Wayne County

House Action: Disapproved

Whereas, there is implication in Blue Cross Insurance that 24 hour around the clock physician coverage in hospitals is a feature of this insurance, and

Whereas, Blue Cross reimburses hospitals for salaries of an increasingly large number of persons not directly related to patient care, and

Whereas, such persons can even have reimbursed salaries for positions in Public Relations, Guard Duty in parking lots, etc., therefore be it

RESOLVED: That Blue Cross be again urged to compensate hospitals for the salaries paid to physicians to supply medical coverage on nights and weekends, and to do physical examinations and other medical services in the vast and growing majority of hospitals not having approved reimbursable internships and/or residency training programs.

● RESOLUTION 72A-24

Membership for Licensure
Gerald Mandell, MD, Wayne County

House Action: Referred to The Council for study

Whereas, licensing and control of medical practices in the State of Michigan is under the aegis of the State Board of Registration in Medicine, and

Whereas, the practice of medicine is a local activity, and

Whereas, the State exerts less effective control on the clinical practice of medicine than does the county medical society, and

Whereas, there is diminished control of medical practice outside of the bounds of the county medical society, and

Whereas, there is a need for effective peer review; therefore be it

RESOLVED: That the State direct the Board of Registration in Medicine to make it mandatory that doctors of medicine in practice must be members of a local county medical society.

● RESOLUTION 72A-25

Medicare Emergency Room Regulations

Jack R. Postle, MD, Northern Michigan

House Action: Adopted as Amended

Whereas, the acute care general hospital Emergency Service area has become a center for community non-emergency medical care, and

Whereas, the public has not responded to significant educational efforts and continue to present themselves to the Emergency Room for non-emergent care, and

Whereas, the high degree of mobility, both permanent and temporary, in the State leads to many patients not having developed a family physician relationship with a doctor and, of necessity, will use hospital Emergency Service for non-emergency care, and

Whereas, the responsibility for patient care has been, and will remain in the hands of the physician in all cases, and

Whereas, the rapidly rising costs of medical care can only be increased by arbitrary rules which require the presence of a physician in the care of the non-emergent patients; therefore be it

RESOLVED: That the requirement of the Conditions of Participation for Hospitals of the Federal Health Insurance for the Aged as published by the U.S. Department of Health, Education and Welfare Social Security Administration, Section 405.1033, paragraph (c), item (3) which states "A physician sees all patients who arrive for treatment in the Emergency Service," be changed, to read . . . "A physician shall be responsible for the care and treatment for all patients who arrive for treatment at the Emergency Service," and that such responsibility may be satisfied in whatever manner the physician deems to be correct and in the best interest of the patient; and be it further

RESOLVED: That the MSMS delegates to the AMA be instructed to sponsor a resolution in the AMA House of Delegates supporting this change in legislation.

● RESOLUTION 72A-26

Re-endorsement of the Usual, Customary and Reasonable Fee

Edward Tallant, MD, Wayne County

House Action: Adopted as Amended

Whereas, The House of Delegates of the Michigan State Medical Society adopted at its 1971 Annual Session Resolution 6 (see below): "Establishment of Uniform Fee Schedule for Medicaid Payment;" and

Whereas, At this same session the House of Delegates reaffirmed its support of payment of the usual, customary and reasonable fee by adoption of Resolution 19 (see below), and

Whereas, The American Medical Association and the Michigan State Medical Society have repeatedly endorsed payment by government and other third parties in accordance with the doctor's usual, customary and reasonable fee, and

Whereas, Title XIX of the Medical Assistance Act specifically states that providers be compensated at the usual, customary and reasonable rate; therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society rescind its approval of Resolution 6 of 1971, titled "Establishment of Uniform Fee Schedule for Medicaid Payment;" and be it further

RESOLVED: That this House of Delegates express its unequivocal opposition to any uniform fee schedule in any guise for any program; and be it further

RESOLVED: That the House of Delegates reaffirm its support of the usual, customary and reasonable fee payment mechanism as in the best interest of the patient and the physician; and be it further

RESOLVED: That this be implemented without modification, regionalization or manipulation on a uniform and state-wide basis.

> **1971 RESOLUTION 6—"Establishment of a Uniform Fee Schedule for Medicaid Payment"**
>
> **Whereas,** Medicaid payments for physician services have been held by the Michigan Department of Social Services at or below 1968 usual and customary charges, and
>
> **Whereas,** these fees for physicians' services were temporarily and arbitrarily cut 10 percent by the Department of Social Services, and
>
> **Whereas,** fiscal responsibility has not been possible under the "usual, customary and prevailing" payment philosophy, and
>
> **Whereas,** actuarially accurate estimates are at best extremely difficult if not impossible using this method of payment, and
>
> **Whereas,** it is totally illogical and discriminatory to have a payment system that pays unequal amounts of money to equally well trained physicians who have provided identical services within the same office, city, county or different geographical areas of the state; therefore be it
>
> **RESOLVED:** That The Council do everything in its power to have established a revised Medicaid payment system which would include a Uniform Fee Schedule for all services and procedures, and be it further
>
> **RESOLVED:** That the most recently approved Michigan Relative Value Scale be used to determine the relative value payment for each service rendered, and be it further
>
> **RESOLVED:** That future adjustments in payments be made in relation to the alteration of costs of delivery of health services on an annual basis.

* * *

> **1971 RESOLUTION 19—"Institution of Legal Action against State of Michigan"**
>
> **Whereas,** the fiscal intermediaries have arbitrarily reduced Medicaid (Title XIX) payments to physicians, and
>
> **Whereas,** Title XIX of the Medical Assistance Act specifically states that providers be compensated at the usual, customary and reasonable rate; therefore be it
>
> **RESOLVED:** That the Michigan State Medical Society reaffirm its commitment to require the fiscal intermediary to compensate, in accordance with the existing law, the provider of medical service at his usual, customary and reasonable rate.

● RESOLUTION 72A-27

A Resolution of Information for Physicians When They Leave Their Community

H. H. Hiscock, MD, Immediate Past President for The Council

House Action: Adopted as Amended

Whereas, the physician-patient relationship implies physician responsibility to provide medical attention to the patient at any time, and

Whereas, physicians, like other persons, leave their community on occasion for educational, recreational and other purposes, and

Whereas, some physicians apparently are under the delusion that they can safely assign their patients to hospital emergency rooms for service during their absence, but in many cases emergency room staff cannot supply the complete medical attention expected in the usual physician-patient relationship, this being particularly true with respect to patients in critical stages, and the physician may thereby fail to fulfill his obligation to provide full-time complete coverage to the patient, and

Whereas, issues may arise from such situations leading to charges of malpractice, abandonment or negligence, therefore be it

RESOLVED: That MSMS inform all its members of the legal and ethical implications of assigning patients to emergency or other broad-scope services during absence from practice.

● RESOLUTION 72A-28

Study of Health Care in Michigan's Penal Systems

Harold H. Hiscock, MD, Immediate Past President for The Council

House Action: Adopted as Amended

Whereas, there are allegations from many quarters relative to the poor medical care for inmates in Michigan's penal system, and

Whereas, most of the rules concerning deliverance are set down by statute and the Corrections Commission, therefore be it

RESOLVED: That an ad hoc committee of MSMS be appointed to investigate, in consultation with the medical directors in the penal system, the legislative restrictions and administrative rules re the delivery of health care in Michigan's penal systems, and to make appropriate recommendations to the Legislature and the Corrections Commission that will better implement deliverance of health care to the inmates. This same service would be made available to other state institutions at their request.

● RESOLUTION 72A-29

Physician Manpower for Rural Areas

Donald N. Fitch, MD, Delta-Schoolcraft County

House Action: Adopted as Amended

Whereas, the needs for more family physicians are great throughout Michigan and especially in many rural communities, and

Whereas, the Upper Peninsula has a population of 312,200 and only 228 doctors of medicine or a ratio of one physician for every 1,234 which is much below the national average of one doctor for every 761, and

Whereas, many Upper Peninsula communities under the leadership of MSMS component medical societies are actively recruiting new physicians for their towns, and

Whereas, several fine colleges and universities in the Upper Peninsula already have strong basic science departments, and

Whereas, there are many outstanding local, state and federal hospitals in the Upper Peninsula which could be utilized effectively for the clinical training of future doctors, and

Whereas, there are many trained, experienced doctors of medicine who are qualified to serve as preceptors and clinical instructors for medical students, therefore be it

RESOLVED: That the Michigan State Medical Society endorse and offer assistance to Michigan State University College of Human Medicine in its new study to determine the feasibility of setting up community-based medical training programs in the Upper Peninsula, and be it further

RESOLVED: That Michigan State University be encouraged to recruit qualified students from rural Michigan for such a new program.

● RESOLUTION 72A-30

Medical Malpractice

R. A. Rasmussen, MD, Kent County

House Action: Adopted as Amended

Whereas, medical malpractice actions in the state continue at an increasing and persistent rate and do constitute a serious medical practice problem, and

Whereas, the cost of medical practice insurance has reached unreasonable and unprecedented levels and does thereby affect the cost of medical care, and

Whereas, ill-founded malpractice actions are encouraged by the present contingency fee for legal services, and because there has been little success in eliminating this method of compensation for legal services, therefore be it

RESOLVED: That MSMS encourage legislative action toward requiring the posting of a suitable security cash deposit or bond as security for the payment by the plaintiff of all costs and reasonable attorney fees incurred by the defendant in defending the action, if the plaintiff fails to recover any damages similar to legislation recently passed in the state of California; and be it further

RESOLVED: That the MSMS delegates to the AMA be instructed to sponsor a resolution in the AMA House of Delegates encouraging similar legislation in all other states.

● RESOLUTION 72A-31

The Drinking Driver Problem

R. A. Rasmussen, MD, Kent County

House Action: Following Substitute Resolution Adopted in lieu of Resolution 72A-31

Whereas, recent incomplete Michigan State Police reports in alcohol related auto accident rates, injuries and fatalities indicate a serious rise (doubling of rate) amongst the 18 to 20 year old drivers since our law on the purchase of alcoholic beverages was liberalized in 1971, and

Whereas, this group of drivers are drinking and driving less well than previously, and which driving constitutes an increased hazard for all drivers—resulting in more intolerable slaughter on our Michigan highways, and

Whereas, as our present drinking driver laws are inadequately and too leniently enforced, and

Whereas, some drivers continue to drive even with suspended driver privileges, therefore be it

RESOLVED: That MSMS encourage additional legislation and stricter enforcement of existing regulations for the control of the drinking driver, and continue to support and improve methods of education and rehabilitation of the drinking driver.

● RESOLUTION 72A-32

Patients' Rights Relative to Privileged Communication & the State Department of Mental Health

Daniel J. Wilhelm, MD, St. Clair County

House Action: Substitute Resolution Adopted as Amended

"Whereas, privileged communication and patient confidentiality are recognized principles and rights in the care of our patients, and

"Whereas, the State Department of Mental Health is violating these principles in requiring mental health and drug addiction agencies submit data for computer logging on each patient served that would include name and social security number, and

"**Whereas,** the State Department of Mental Health is threatening to stop all funds to those agencies who do not comply with this identification procedure, and

"**Whereas,** such identification will also turn people away from seeking these services they need, and

"**Whereas,** the Shiawassee County Mental Health Services Board has initiated court action to cause the State Department of Mental Health to stop this harmful identification practice, and

"**Whereas,** physicians may become liable for suit because of breach of confidentiality, and

"**Whereas,** action is imminent, therefore be it

"**RESOLVED:** That Michigan State Medical Society support the continuing rights of the patient for privileged communication and confidentiality, and be it further

"**RESOLVED:** That this House direct MSMS legal department to file an amicus curiae brief in the event of an appeal in support of the Shiawassee County Mental Health Services Board action against the Michigan State Department of Mental Health."

SPECIAL MEMBERSHIPS

The Reference Committee on Special Memberships, Joseph J. Woods, MD, Chairman, recommended approval of the following special memberships as recommended by the component medical societies and certified by the Secretary of MSMS in accordance with the Bylaws:

RETIRED MEMBERSHIPS

Bay-Arenac-Iosco—John W. Asline, MD; Stanley M. Pearson, MD
Calhoun—Robert S. Simpson, MD
Genesee—Mary Ruth Oldt, MD; Otto J. Preston, MD
Grand Traverse-Leelanau-Benzie—Claude I. Ellis, MD; James W. Hall, MD; Nevin Huene, MD
Ingham—Arthur L. Stanley, MD
Jackson—Alfred M. Sirhal, MD
Kalamazoo—Roscoe C. Hildreth, MD; Albert B. Hodgman, MD; Robert M. Jennings, MD; Paul A. Koestner, MD
Kent—Johannes D. Plekker, MD
Marquette-Alger—John C. Harkin, MD
Midland—Dan. J. Bulmer, MD
Muskegon—Park S. Bradshaw, MD; Howard J. Kerr, MD; Edward H. Wagenaar, MD
North Central—Richard E. Olsen, MD
Northern Michigan—Bernhard T. Alm, MD
Ottawa—Frederick W. DeYoung, MD; Herman P. Harms, MD
Saginaw—William T. Hyslop, MD; V. Robert Mikan, MD; Richard S. Ryan, MD
St. Joseph—Lawrence A. Berg, MD; George D. Shaw, MD
Washtenaw—Marvin R. Hannum, MD
Wayne—Eugene J. Alexander, MD; James J. Boccia, MD; Martin F. Bruton, MD; James J. Coyle, MD; Roger W. DeBusk, MD; Frank R. Ellis, MD; Lawrence E. Filkin, MD; John H. Ganschow, MD; John E. Hauser, MD; Charles W. Henderson, MD; Henry T. Holt, MD; Luis J. Iglesias, MD; Willard R. Lenz, MD; Irving Levitt, MD; Joseph H. Lorber, MD; Wm. S. Lova, MD; Stuart F. Meek, MD; Victor E. Nelson, MD; Reuben I. Shapiro, MD; Jacob F. Wenzel, MD

LIFE MEMBERSHIPS

Allegan—Gladwin E. Ramseyer MD
Alpena-Alcona-Presque Isle—Edward A. Hier, MD; Wm. E. Nesbitt, MD
Branch—Harold K. Schillinger, MD
Calhoun—Archie E. Humphrey, MD
Chippewa-Mackinac—W. F. Mertaugh, MD
Delta-Schoolcraft—Louis P. Groos, MD
Eaton—Lester G. Sevener, MD; Albert W. Myers, MD
Genesee—Isadore H. Gutow, MD; Charles J. Scarvada, MD; Floyd H. Steinman, MD
Gogebic—Michael A. Gertz, MD
Gratiot-Isabella-Clare—Earl C. Wilson, MD
Hillsdale—Charles L. Hodge, MD
Ingham—Thomas A. Lucas, MD
Kalamazoo—Sherman E. Andrews, MD; John V. Fopeano, MD; Cornelius A. Alexander, MD
Kent—W. Clarence Beets, MD
Lenawee—Howard H. Heffron, MD
Macomb—Anthony C. Poretta, MD; Russell F. Salot, MD
Manistee—Ernest C. Hansen, MD
Marquette-Alger—Joseph P. Bertucci, MD
Northern Michigan—Loren C. Spademan, MD
Oakland—Alvin G. Lambert, MD
Ottawa—Marinus H. Hamelink, MD
Van Buren—John F. Itzen, MD
Washtenaw—John S. DeTar, MD; Wheeler H. Kern, MD
Wayne—George H. Agnew, MD; Clifford D. Benson, MD; Sydney S. Berke, MD; Leo J. Croll, MD; Forest D. Dodrill, MD; Irving I. Edgar, MD; Aaron A. Farbman, MD; William R. Flora, MD; Herbert B. Gaston, MD; Theophilus H. Heenan, MD; Stanley A. Heyner, MD; Morton M. Hochman, MD; Howard T. Howlett, MD; Theodore H. Hunt, MD; Louis Koren, MD; Edward W. Krass, MD; Clarence E. Maguire, MD; R. J. Mendelssohn, MD; Maurice P. Meyers, MD; John J. Pollack, MD; Francis P. Rhoades, MD; Charles S. Syphax, MD; George A. Troester, MD; George A. West, MD; Theodore M. White, MD; Merton C. Wilson, MD

THE HOUSE adopted the report of the Reference Committee.

PRESENTATIONS AND AWARDS

FIFTY YEAR AWARDS

President Sidney Adler, MD, presented the Fifty Year Awards to:

Harry E. August, MD, *Wayne County*
Oscar L. Barland, MD, *Wayne County*
George M. Brown, MD, *Bay County*
G. R. Bullen, MD, *Jackson County*
Clarence J. Carpenter, MD, *Wayne County*
Cecil Corley, MD, *Jackson County*
Albert F. DeGroat, MD, *Wayne County*
Cuthbert E. De May, MD, *Jackson County*
Isla G. DePree, MD, *Drummond Island, Kent County*
Lloyd S. Dunkin, MD, *Montcalm County*
Robert Durham, MD, *Wayne County*
Joseph M. Erman, MD, *Wayne County*
Harold B. Fenech, MD, *Wayne County*
Isidor H. Friedman, MD, *Wayne County*
Lambert Geerlings, MD, *Newaygo County*
Angus G. Goetz, MD, *Wayne County*
Dewey R. Heetderks, MD, *Kent County*
Colonel R. Henry, MD, *Oakland County*
John P. Hubbard, MD, *Wayne County*
Hugo M. Jardine, MD, *North Central Counties*
Stanley J. Joyce, MD, *Wayne County*
Arthur H. Kretchmar, MD, *Genesee County*
Elmore F. Lewis, MD, *Jackson County*
J. Hugh Lewis, MD, *Wayne County*
Ezra Lipkin, MD, *Wayne County*
William G. Mackersie, MD, *Wayne County*
James R. Marshall, MD, *Wayne County*
Clarke M. McColl, MD, *Wayne County*
Earl G. Merritt, MD, *Wayne County*
Clinton C. Mills, MD, *Wayne County*
Harry A. Pearse, MD, *Wayne County*
Archibald C. Pfeifer, MD, *Genesee County*
John E. Pittman, MD, *Wayne County*
Philip A. Riley, MD, *Jackson County*
Lutfi M. Sa Di, MD, *Wayne County*
William J. Scott, MD, *Wayne County*
Henry L. Smith, MD, *Wayne County*
Frederick A. Sturm, MD, *Macomb County*
Cullen E. Sugg, MD, *Kent County*
William R. Torgenson, MD, *Kent County*
Rita B. Tower, MD, *Genesee County*
Inga Werness, MD, *Genesee County*
Thomas N. Wills, MD, *Genesee County*

BLUE SHIELD AWARDS

Robert H. Hamburg, MD, Chairman, Blue Shield Board, presented awards to retiring members of the Board.

Roy J. Gerard, MD, *Saginaw County*
Paul T. Lahti, MD, *Oakland County*
Adrian J. Neerken, MD, *Kalamazoo County*

EMPLOYEE AWARDS

Secretary Kenneth H. Johnson, MD, presented the following employee awards as previously authorized by the House of Delegates:

Vada Davis—20 years of service
Mary K. Brewbaker—15 years of service
Richard M. Campau—10 years of service
Margaret J. Berry—5 years of service

NATIONAL PRESIDENTS AWARDS

Awards were presented to the following for their service as presidents of national medical organizations:

William Jend, Jr., MD, Detroit, Industrial Medical Association

H. Marvin Pollard, MD, Ann Arbor, American Cancer Society

Francis P. Rhoades, MD, Detroit, American Geriatrics Society

Austin Smith, MD, Detroit, International Federation of Pharmaceutical Manufacturers Associations

Myron Wegman, MD, Ann Arbor, American Public Health Association

Earl E. Weston, MD, Detroit, Medical Amateur Radio Council

FLAG AWARDS

Awards were presented to the following doctors who have served as presidents of state-wide non-medical organizations:

Gerald Breneman, MD, Farmington, President until June 1972, Michigan Heart Association

Donald C. Overy, MD, Birmingham, current president, Michigan Heart Association

Nicholas Cherup, MD, Bloomfield Hills, Michigan Association of Physical Medicine and Rehabilitation

Henry D. Kaine, MD, Detroit, Michigan Diabetes Association

John W. Moses, MD, Detroit, Kenny-Michigan Rehabilitation Foundation

John W. Sigler, MD, Detroit, Michigan Chapter, Arthritis Foundation

ELECTIONS

The House of Delegates elected the following MSMS Officers, Councilors, and American Medical Association Delegates and Alternate Delegates:

Officers

President-Elect—Brooker L. Masters, MD, Fremont
Speaker of the House—Vernon V. Bass, MD, Saginaw
Vice Speaker of the House—James D. Fryfogle, MD, Southfield

Councilors

1st District—Brock E. Brush, MD, Detroit
2nd District—Robert M. Stow, MD, Lansing
3rd District—Robert M. Leitch, MD, Battle Creek
9th District—Adam McClay, MD, Traverse City
11th District—Leland E. Holly, II, MD, Muskegon
13th District—Donald T. Anderson, MD, Kingsford
15th District—Paul T. Lahti, MD, Royal Oak (additional councilor authorized by the 1972 Annual Session of the House of Delegates)

Delegates to the American Medical Association

(January 1, 1973 to December 31, 1974)
Donald N. Sweeny, Jr., MD, Detroit
John J. Coury, MD, Port Huron
George W. Slagle, MD, Battle Creek
James C. Danforth, Jr., MD, Grosse Pte. Woods

Alternate Delegates to the American Medical Association

(January 1, 1973 to December 31, 1974)
(in order of seniority)

Marjorie Peebles Meyer, MD, Detroit
Vernon V. Bass, MD, Saginaw
Robert C. Prophater, MD, Bay City
Kenneth J. Ray, MD, Grosse Ile

REFERENCE COMMITTEES — 1972

COMMITTEE A

Louis E. Heideman, MD, Wayne, *Chairman*
Donald N. Fitch, MD, Delta-Schoolcraft
Henry T. Forsyth, MD, Shiawassee
Worth W. Henderson, MD, Oakland
Marion G. McCall, MD, Wayne
Richard J. McMurray, MD, Genesee
Adrian J. Neerken, MD, Kalamazoo

Councilor Advisors:
Ross V. Taylor, MD, Jackson
Donato F. Sarapo, MD, Adrian
Edward J. Tallant, MD, Detroit

COMMITTEE B

William Haeck, MD, Kent, *Chairman*
Charles E. Conaway, MD, Lapeer
Roy J. Gerard, MD, Saginaw
Robert E. Paxton, MD, Newaygo
Kenneth J. Ray, MD, Wayne
James P. Strong, MD, Ontonagon
Paul M. Zavell, MD, Wayne

Councilor Advisors:
Noyes L. Avery, Jr., MD, Grand Rapids
Robert C. Prophater, MD, Bay City
Louis R. Zako, MD, Westland

COMMITTEE C

John R. Franck, MD, Gogebic, *Chairman*
Marshall J. Blondy, MD, Wayne
Sidney E. Chapin, MD, Wayne
Harold F. Falls, MD, Washtenaw
Glenn E. Moore, MD, Genesee
Robert E. Rice, MD, Ionia-Montcalm
Paul L. Trump, MD, Dickinson-Iron

Councilor Advisors:
Brock E. Brush, MD, Detroit
William A. DeYoung, MD, Saginaw
James H. Tisdel, MD, Port Huron

COMMITTEE D—(Officers Reports)

Thomas R. Berglund, MD, Kalamazoo, *Chairman*
D. Bonta Hiscoe, MD, Ingham
Richard L. Lamont, MD, Wayne
George Mogill, MD, Wayne
Gerald W. Morris, MD, Macomb
Richard A. Rasmussen, MD, Kent
Gerald Shiener, MSU

Councilor Advisors:
Brooker L. Masters, MD, Fremont
Robert M. Leitch, MD, Battle Creek

COMMITTEE E

Robert J. Toteff, MD, Saginaw, *Chairman*
Joseph A. Caruso, MD, Ob/Gyn Section
Leland E. Holly, II, MD, Muskegon
William S. Jones, Jr., MD, Menominee
Gerald H. Mandell, MD, Wayne
Arthur A. Ulmer, MD, Wayne
Neal A. Vanselow, MD, Washtenaw

Councilor Advisors:
Raymond L. Hockstad, MD, Escanaba
W. Kaye Locklin, MD, Kalamazoo
Adam C. McClay, MD, Traverse City

COMMITTEE F

Frank B. Walker, MD, Wayne, *Chairman*
John W. Grigg, MD, Otolaryngology Section
George T. Kelleher, MD, Calhoun
George Porretta, MD, Wayne
Winston B. Prothro, MD, Public Health &

Preventive Medicine Section
Jack M. Stack, MD, Gratiot-Isabella-Clare
S. A. Yannitelli, MD, Calhoun

Councilor Advisors:
Donald T. Anderson, MD, Kingsford
Harold H. Hiscock, MD, Flint
Ralph R. Cooper, MD, Detroit

CONSTITUTION & BYLAWS

Stuart M. Gould, MD, Washtenaw, *Chairman*
Donald I. Bryan, MD, Wayne
Paul R. Dumke, MD, Wayne
David J. Millard, MD, Van Buren
Frank H. Power, MD, Grand Traverse-Leelanau-Benzie
Lee B. Stevenson, MD, Wayne
Leo W. Walker, MD, Pathology Section

Councilor Advisors:
Kenneth H. Johnson, MD, Lansing
Donald N. Sweeny, Jr., MD, Detroit
Sydney Scher, MD, Mt. Clemens

WAYS & MEANS

David Siegel, MD, Urology Section, *Chairman*
Robert W. Black, MD, Wayne
James Blodgett, MD, Oakland
Norman J. Bolton, MD, Wayne
John W. Moses, MD, Wayne
Charles L. Oppy, MD, North Central
Jack R. Postle, MD, Northern Michigan

Councilor Advisors:
Ernest P. Griffin, Jr., MD, Flint
John R. Ylvisaker, MD, Pontiac
Frank Bicknell, MD, Detroit

CREDENTIALS & TELLERS

Keate T. McGuncgle, MD, Sanilac, *Chairman*
Bruce D. Bauer, MD, Oakland
Arthur B. Eisenbrey, MD, Wayne
Conrad R. Lam, MD, Wayne
Earl A. Rinkenberger, MD, Macomb
Charles H. Willison, MD, Midland
Michael N. Zelenock, MD, Surgery Section

RULES & ORDER OF BUSINESS

Robert M. Stow, MD,, Ingham, *Chairman*
Fred Brace, MD, Kent
Hira E. Branch, MD, Orthopedic Section
Ned I. Chalat, MD, Wayne
James C. Danforth, Jr., MD, Wayne
John H. McLaughlin, MD, Oakland
Henry A. Scovill, MD, Washtenaw

SPECIAL MEMBERSHIPS

Joseph J. Woods, MD, Wayne, *Chairman*
Alvin Bonzelaar, MD, Ottawa
Donald D. Finlayson, MD, Chippewa-Mackinac
Thomas M. Flake, MD, Wayne
R. William Holden, WSU
James A. Read, MD, Oakland
Eber B. Sherman, MD, Eaton

PARLIAMENTARIAN

A. Stewart Kerr, Detroit

1972 MSMS HOUSE OF DELEGATES RECORD OF ATTENDANCE

	Meetings				
	1st	2nd	3rd	4th	5th
OFFICERS					
Speaker:					
Vernon V. Bass, MD	x	x	x	x	x
Vice Speaker:					
James D. Fryfogle, MD	x	x	x	x	x
Immed. Past President:					
Harold H. Hiscock, MD	x	x	x	x	x
Secretary:					
Kenneth H. Johnson, MD	x	x	x	x	x

COUNTY MEDICAL SOCIETY DELEGATES

	Meetings				
	1st	2nd	3rd	4th	5th
ALLEGAN					
R. L. Plagenhoef, MD	x	x	x	x	—
ALPENA-ALCONA-PRESQUE ISLE					
F. C. O'Dell, Jr., MD	—	x	x	x	x
BARRY					
Robert J. Huebner, MD	—	x	x	x	x
BAY-ARENAC-IOSCO					
Robert Ferguson, MD	x	x	—	—	—
Robert C. Prophater, MD	x	x	x	x	x
BERRIEN					
Fredk. H. Lindenfeld, MD	x	x	x	x	x
F. Alan Kennedy, MD	x	x	x	x	x
BRANCH					
Henry C. Gomley, MD					
Malcolm D. Steider, MD	x	x	x	x	x
CALHOUN					
George T. Kelleher, MD	x	x	x	x	x
S. A. Yannitelli, MD	—	x	x	x	—
Walter B. Long	x	x	x	x	x
CASS					
Aaron K. Warren, MD	—	x	x	—	—
CHIPPEWA-MACKINAC					
Donald D. Finlayson, MD	x	x	x	x	—
CLINTON					
James M. Grost, MD					
Victor L Sheline, MD	—	—	x	x	—
DELTA-SCHOOLCRAFT					
Donald N. Fitch, MD	x	x	x	x	x
DICKINSON-IRON					
Paul L. Trump, MD	x	x	x	x	—
EATON					
Eber B. Sherman, MD	x	x	x	x	x
GENESEE					
Clifford W. Colwell, MD	x	x	x	x	x
Richard J. McMurray, MD	x	x	x	x	—
Glenn E. Moore, MD	x	x	x	x	x
Lewis E. Simoni, MD	x	x	x	x	x
John C. Benson, MD	x	x	x	x	—
John W. MacKenzie, Jr., MD	x	x	x	x	—
Charles A. Thompson, MD					
John Quin, Jr., MD	x	x	x	x	—
GOGEBIC					
John R. Franck, Jr., MD	x	x	x	x	x
GRAND TRAVERSE-LEELANAU-BENZIE					
Frank H. Power, MD	x	x	—	x	—
Arthur F. Dundon, MD	x	x	x	x	x
GRATIOT-ISABELLA-CLARE					
Jack M. Stack, MD	—	x	x	x	x
HILLSDALE					
Clark B. Smith, MD	x	x	x	x	—
HOUGHTON-BARAGA-KEWEENAW					
Paul G. Goodreau, MD	x	x	x	x	—
HURON					
Charles W. Oakes, Jr., MD	x	x	x	x	x
INGHAM					
Thomas C. Blair, MD	x	x	x	x	x
Harry C. George, MD	x	x	x	x	x
Robert M. Daugherty, MD	x	x	x	x	x
D. Bonta Hiscoe, MD	x	x	x	x	x

	Meetings				
	1st	2nd	3rd	4th	5th
Henry E. Malcolm, MD	x	x	x	x	x
George D. Stilwill, MD	x	x	x	x	x
Robert M. Stow, MD	x	x	x	x	x
IONIA-MONTCALM					
Robert E. Rice, MD	x	x	x	x	x
JACKSON					
Richard C. Deming, MD	x	x	x	x	—
Edward R. Weddon, MD	x	x	x	x	x
KALAMAZOO					
Adrian J. Neerken, MD	x	x	x	x	—
Thomas E. Andrews, MD	—	x	x	x	—
Robert C. Kettunen, MD	—	x	—	—	—
David E. Boswell, MD	x	—	—	—	—
Thomas R. Berglund, MD	x	x	x	x	x
KENT					
Fred C. Brace, MD	x	x	x	x	x
Frederick S. Gillett, MD Joseph R. Lentini, MD	x	x	—	x	x
William Haeck, MD	x	—	x	x	x
Richard A. Rasmussen, MD	x	x	x	x	x
Harvey M. Andre, MD	x	x	x	x	x
Victor A. Notier, MD	x	x	x	x	x
William E. Kincaid, MD	x	x	x	x	x
Jack G. Lukens, MD	x	x	x	x	—
Kornelius Van Goor, MD	x	x	x	x	—
LAPEER					
Charles E. Conaway, MD	x	x	x	x	x
LENAWEE					
Richard H. Gascoigne, MD	x	x	x	x	x
LIVINGSTON					
Edwin S. Woodworth, MD	x	x	x	x	x
LUCE					
Not Represented					
MACOMB					
Earl G. Moehn, MD	x	x	x	x	x
Gerald W. Morris, MD	x	—	—	x	x
Earl A. Rinkenberger, MD	x	x	x	x	x
Thomas J. Setter, MD	—	x	x	x	x
MANISTEE					
David A. Wild, MD Vickers Hansen, MD	—	x	x	x	x
MARQUETTE-ALGER					
George M. Wilson, Jr., MD	x	x	x	x	x
MASON					
William F. Sutter, MD	x	x	x	x	x
MECOSTA-OSCEOLA-LAKE					
Jerome A. Conrad, MD	x	x	x	x	x
MENOMINEE					
William S. Jones, Jr., MD	x	x	x	x	x
MIDLAND					
Charles H. Willison, MD	x	x	x	x	x
MONROE					
Warren J. Liedel, MD	x	x	x	x	x
MUSKEGON					
Howard V. Sanden, MD	x	x	x	x	x
Leland E. Holly, II, MD	x	x	x	x	x
Richard T. Allen, MD	x	x	x	x	x
NEWAYGO					
Robert E. Paxton, MD	x	x	x	x	x
NORTH CENTRAL					
Charles L. Oppy, MD	x	x	x	x	x

	Meetings				
	1st	2nd	3rd	4th	5th
NORTHERN MICHIGAN					
Jack R. Postle, MD	—	x	x	x	x
G. B. Saltonstall, MD	x	x	x	x	x
OAKLAND					
Edward E. Elder, Jr., MD	—	—	x	x	—
Paul T. Lahti, MD	x	x	—	x	x
Arnold L. Brown, MD	x	x	—	—	—
Bruce D. Bauer, MD	x				
E. Wm. Bauer, MD		x	x	x	—
James A. Read, MD	—	x	x	x	—
Kenneth L. Urwiller, MD	x	x	—	x	—
John B. Bryan, MD	—	x	x	x	x
Edwin J. Westfall, MD	x	x	x	x	x
Worth W. Henderson, MD	—	x	x	x	x
John H. McLaughlin, MD	x	x	x	x	x
Francis A. Martin, MD	x	x	x	x	—
OCEANA					
John J. Vrbanac, MD	x	x	x	x	x
ONTONAGON					
James P. Strong, MD	—	—	x	x	—
OTTAWA					
Melvin J. Frieswyk, MD	x	x	x	x	x
SAGINAW					
Jack L. Barry, MD	—	x	x	x	—
Roy J. Gerard, MD	—	x	x	x	—
Robert J. Toteff, MD	x	x	x	x	x
Richard C. Hausler, MD	x	x	x	x	x
ST. CLAIR					
Charles N. Hoyt, MD	x	x	x	x	x
Daniel J. Wilhelm, MD	x	x	x	x	x
ST. JOSEPH					
Robert H. Evans, MD	x	x	x	x	x
SANILAC					
Keate T. McGunegle, MD	x	x	—	—	—
SHIAWASSEE					
Henry T. Forsyth, MD	x	x	x	x	x
TUSCOLA					
Herbert L. Nigg, MD Maurice H. Chapin, MD	x	x	x	x	x
VAN BUREN					
David J. Millard, MD	x	—	x	x	x
WASHTENAW					
Henry A. Scovill, MD	x	x	x	x	x
John W. Henderson, MD	x	—	x	x	x
Stuart M. Gould, MD	x	x	x	x	—
Beverly C. Payne, MD	—	x	x	x	x
Lyle D. Elliott, MD	x	x	x	x	—
Harold F. Falls, MD	x	x	x	x	x
George H. Koepke, MD	x	x	x	x	x
Harry A. Towsley, MD Robert J. Fisher, MD	—	—	—	x	—
Neal A. Vanselow, MD	x	x	x	x	—
WAYNE					
Homer M. Smathers, MD	x	x	x	x	x
Sidney E. Chapin, MD	x	x	x	x	—
Ned I. Chalat, MD	x	x	x	—	x
Marjorie P. Meyers, MD	x	x	x	x	—
James C. Danforth, MD	x	x	x	x	x
James B. Blodgett, MD	x	x	x	x	x
Brock E. Brush, MD	x	x	—	—	—
Frank B. Bicknell, MD	x	x	x	x	—
Edward J. Tallant, MD	x	—	x	x	x
Ralph R. Cooper, MD	x	x	x	x	x
Louis E. Heideman, MD	x	x	x	x	—
Alexander Blain, II, MD	—	x	—	—	x
C. Jackson France, MD	x	x	x	x	x
Robert H. Hamburg, MD	x	—	—	x	x

	Meetings				
	1st	2nd	3rd	4th	5th
John W. Moses, MD	x	x	x	x	x
Francis P. Rhoades, MD	x	x	x	x	x
Charles E. Darling, MD	x	x	x	x	x
Raymond J. Barrett, MD	—	—	—	x	—
Milton R. Weed, MD	x	x	x	x	x
Robert K. Whiteley, MD	x	x	—	—	—
Benjamin Jeffries, MD	x	x	x	x	x
James M. Kennary, Sr., MD	—	x	x	x	—
Thomas M. Flake, MD	x	x	x	x	x
George F. Porretta, MD	x	x	x	x	—
Richard D. Anslow, MD	—	x	x	x	—
Eli J. Igna, MD	x	x	x	x	—
Irvin A. Wilner, MD	—	—	x	—	x
Louis R. Zako, MD	x	x	x	—	x
Henry M. Domzalski, MD	x	x	x	x	x
Frank B. Walker, II, MD	x	x	x	x	x
Robert W. Black, MD	x	x	x	x	—
Thomas Ganos, MD	x	x	—	x	x
Alfred Golden, MD	x	x	x	x	x
Arthur B. Eisenbrey, MD	x	x	—	x	x
Gerald H. Mandell, MD	x	x	x	x	—
Arthur A. Ulmer, MD	—	x	—	—	—
Marshall J. Blondy, MD	—	x	x	x	—
Paul M. Zavell, MD	x	—	x	—	—
Kenneth J. Ray, MD	x	—	x	x	x
Donald I. Bryan, MD	x	—	—	—	—
Lee B. Stevenson, MD	x	x	x	—	—
Ralph H. Pino, MD	x	x	x	x	x
John W. Moynihan, MD	x	x	—	—	—
Charles Kessler, MD	x	—	—	—	x
John F. Cotant, MD	x	—	—	—	—
James J. Humes, MD	x	x	—	x	—
Donald W. Visscher, MD	x	—	—	—	x
Maurice A. Frankel, MD	x	x	—	—	—
Louis F. Hayes, MD	x	x	x	—	x
Cecelia F. Hissong, MD	x	—	x	x	—
Robert J. Solomon, MD	—	x	—	—	—
Joseph J. Woods, MD	x	x	x	x	x
Marion G. McCall, Jr., MD	x	x	—	x	—
I. W. Silver, MD	x	—	—	—	—
William O. Mays, MD	—	x	—	—	—
WEXFORD-MISSAUKEE					
Dennis E. Van Alst, MD	x	x	x	x	x

STUDENT AMERICAN MEDICAL ASSOCIATION DELEGATES

MICHIGAN STATE UNIVERSITY					
Not Represented					
WAYNE STATE UNIVERSITY					
R. William Holden					
John Bruder	—	x	—	x	—
UNIVERSITY OF MICHIGAN					
Bernard Stulberg	—	—	x	—	—

SECTION DELEGATES

	Meetings				
	1st	2nd	3rd	4th	5th
ALLERGY & APPLIED IMMUNOLOGY					
James A. McLean, MD	—	x	x	x	—
ANESTHESIOLOGY					
William B. Jensen, Jr., MD					
Thomas B. Busard, MD	x	x	x	x	x
DERMATOLOGY					
Robert J. Schoenfeld, MD	x	—	—	—	x
GASTROENTEROLOGY					
Not Represented					
GENERAL PRACTICE					
Gordon W. Willoughby, MD	x	x	x	—	x
INTERNAL MEDICINE					
William G. McDonald, MD	x	—	x	—	x
NEUROLOGY					
Mark C. Levine	—	x	x	x	—
NEUROLOGICAL SURGEONS					
Not Represented					
OBSTETRICS-GYNECOLOGY					
Joseph A. Caruso, MD	—	x	x	x	x
OCCUPATIONAL MEDICINE					
Not Represented					
OPHTHALMOLOGY					
Not Represented					
ORTHOPEDIC SURGERY					
Hira E. Branch, MD	x	—	x	—	—
OTOLARYNGOLOGY					
John W. Grigg, MD	x	x	x	—	—
PATHOLOGY					
Leo W. Walker, MD	x	x	—	—	—
PEDIATRICS					
Not Represented					
PHYSICAL MEDICINE					
Jack R. Grommons, MD	x	x	x	x	x
PLASTIC SURGERY					
Not Represented					
PROCTOLOGY					
Not Represented					
PSYCHIATRY					
Stephen C. Mason, III, MD	x	x	x	x	—
PUBLIC HEALTH & PREVENTIVE MEDICINE					
Winston B. Prothro, MD	—	—	x	x	x
RADIOLOGY					
Not Represented					
SURGERY					
Michael N. Zelenock, MD	x	x	—	x	—
THORACIC SURGERY					
Not Represented					
David Siegel, MD	x	x	x	x	x

On Jan. 24, the MSMS Council approved the recommendation of the MSMS Committee on Governmental and Medical Care Programs: that MSMS take the initiative to develop a state-coordinated, locally-operated plan for Professional Standards Review Organizations in Michigan. PSROs are required by the Social Security Amendments of 1972. They and their implications were studied carefully by the MSMS committee, which then developed a rationale for MSMS involvement. The committee's full report to the Council follows.

MSMS takes the lead to shape PSROs in Michigan

By Robert E. Rice, MD, Chairman
Committee on Government Medical Care Programs

The Committee on Governmental Medical Care Programs was directed by The MSMS Council to study and analyze PL 92-603 (HR 1) and report to The Council with recommendations. This first Committee report on the law deals only with the Professional Standards Review Organizations section. Because of the length and complexity of PL 92-603, and the overriding implications of PSRO, the Committee felt constrained to focus its attention first on PSRO. The Committee has the remainder of the law under study and will report in due time.

Method of Study

The Committee provided its members with analyses and other pertinent information about PSROs as this information became available. Some of this information also was forwarded to Council members. Chairman Robert E. Rice, MD, Greenville, appointed Kenneth Ray, MD, of Grosse Ile and John Wilson, MD, of Grand Rapids to accompany him, with staff, to Washington, D.C., Dec. 18, for in-depth interviews with AMA's Washington staff and the staff of the Office of Assistant Secretary of HEW for Health and Scientific Affairs. Thereafter, the full committee met to consider all information available including reports from the three physicians who had been to Washington.

Committee Findings

1. A PSRO is an organization for peer review required by legislation. PSROs are requested to review services provided under Medicare and Medicaid. PSROs will determine if such services are medically necessary, whether they comply with professional standards, and if in-patient services could be provided on an out-patient basis, or more economically in a facility of a different type.
2. PL 92-603 defines that PSROs will be made up of doctors of medicine and osteopathy only. The original Bennett Amendment excluded physicians from review of medical services.
3. HEW is directed to designate by Jan. 1, 1974, local PSRO areas. The contract for review services will be directly between the Federal government and the local PSRO. However, there will be a National Professional Standards Review Council appointed by the secretary of HEW consisting of 11 physicians "of recognized standing and distinction in the appraisal of medical practice," and a majority of whom will be recommended by "national organizations representing practicing physicians." There also will be a State Professional Standards Review Council in states with three or more PSROs, to consist of one representative from each PSRO, four physicians (two nominated by the state medical society and two by the state hospital association), and four members of the public.
4. It appears that 1973 will be used mainly to designate PSRO areas and then 1974 and 1975 to implement PSROs in those areas. Thereafter, HEW will move into areas without PSRO implementation and develop PSRO mechanisms with or without physician cooperation.
5. The well-publicized "300" as a minimum number of doctors in a PSRO is, in fact, a euphemism. PSROs with less than 300 will be considered as well as

PSROs with more than 300. An optimum size probably will be variable, based on geographic, social, economic and service area similarities.

6. The status of implementation of PSROs is clouded by the resignation of Merlin K. DuVal, MD, the Assistant Secretary for Health and Scientific Affairs. As of the writing of this report, his successor has not been named. The change from Mr. Richardson to Mr. Weinberger as Secretary of HEW, and several other significant changes in personnel complicates the issue so far as policy, guidelines and directives are concerned. Therefore, there are no specifics on any of the details.
7. During this change in personnel, HEW staffers are preparing a series of alternative policies and guidelines on PSROs from which the next assistant secretary can select. These alternatives include active participation at the state level (we were told) by aggressive, innovative state medical societies. For instance, at the moment we might propose a plan for delineating PSROs.
8. PSROs under PL 92-603 initially will review institutional medical care only. It can choose to review ambulatory care if it desires, but does not have to. HEW speculates that eventually ambulatory care will be reviewed by PSROs.
9. *The stated objectives of PSRO legislation are to improve quality of medical services and provide for a physician-run review program. However, AMA and HEW staff, the MSMS study committee and the full Committee on Governmental Medical Care Programs, all concur that the unstated objective is to contain costs of government medical programs. In truth, this is a paradox. It is not likely that there is or will be over-utilization or bad utilization to the degree that it will affect the total cost of health care. Rather, PSROs are more likely to result in additional services, if they are to improve the quality of care, which will increase the total cost. If the government really wants to decrease its total dollar investment, its only alternative would seem to be to decrease services, which it probably has no intention of doing. In fact, we were informed that some increase in costs would be tolerable to HEW, but that a deceleration of rising costs will be mandatory. We must make it understood by all concerned, including the public, that PSROs will not reduce the total cost of health care in the country or state.*
10. State and county medical societies are excluded by law from operating as PSROs. A branch of organized medicine cannot directly provide professional standards review organizations.
11. A PSRO must include all physicians in the designated area who wish to participate. Osteopaths have the same privileges as MDs. No one shall be excluded for reason of not belonging to an organized medical group. There will be no dues. All Medicaid and Medicare patients will be subject to review whether a physician participant or not.
12. It was obvious to the three visiting physicians that probably organized medical societies are the most logical route for HEW to effectively reach and implement PSROs at the local level.
13. The local component medical society may preserve its identity by participating in the sponsorship as the "parent" of the PSRO for its area.
14. It appears that PSROs can be an organization developed by state and local medical societies. It appears that HEW may look to organized medicine for guidance and experience.
15. HEW will welcome proposals for pilot projects, demonstrations, etc. HEW does *not* visualize a uniform, monolithic PSRO organizational structure. Such proposals, however, must clearly spell out the objectives of PSROs for review of medical care.
16. HEW will accept—in fact, encouraged us to submit—our own prospectus for PSRO on a state-oriented basis. This, despite their statement that HEW will deal directly with localized PSRO, not with a "state plan."
17. HEW has *not* precluded state societies from being actively involved in these programs. HEW agreed with our observation that the state medical society has a logical and strong role to play in implementing PSROs; in fact, it may be the only instrument which can do so.
18. We were told the best way for the state society to get involved in PSRO is to get involved *early*. HEW will accept a letter of intent, a prospectus, a plan—but the message is clear; get in *now* with our best creative thinking before

The AMA and PSROs

By Donald N. Sweeny, Jr. MD
Chairman, MSMS Delegation to AMA

Professional Service Review Organizations were the No. 1 issue at the AMA Clinical Convention in November.

The House devoted a great deal of time to consideration of Professional Service Review Organizations and their impact on organized medicine, medical practice, the individual physician and his patients. A seminar took up the entire afternoon prior to the opening of the convention. The options were discussed fully and the House adopted the position that the AMA "provide a dominant role of leadership in the implementation of the PSRO program to assure that the best interests of the public and the profession are preserved." The House noted that, while PSRO legislation was pending in Congress, the AMA had questioned whether its emphasis on control might not lead to a lowering of the quality of care. Now, since it is law, the AMA is determined that the rules and regulations guard the interests of the public and the profession. An AMA Advisory Commission on Professional Standards Review will be created by the Board of Trustees. It will include members of the Board and the Council of Medical Service. In addition, the Board will invite appropriate organizations to participate.

The many responsibilities of this commission were detailed:

a. To provide input from the medical profession in development of the rules and regulations which will govern the PSRO program;

b. To assist state medical associations, or state medical associations in accord with county medical societies, in developing PSROs and to recommend structures and operating mechanisms for such PSROs.

c. To aid in defining appropriate geographic boundaries for PSROs especially in instances where more than one state may be involved;

d. To develop and transmit to PSROs recommended operational procedures;

e. To assure that the development of "norms of health care services" called for in the law in regard to medical necessity of care provided, length of stay, and appropriations of the site of care shall have full input from the various medical specialties and the medical profession generally and shall recognize regional and local differences in patterns of medical care;

f. To identify sources of existing data and experience which can be used as a basis for developing such regional or local norms of health care services as well as identifying those areas in which current data are insufficient for this purpose and need further development;

(Continued on Page 128)

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the decision has to be made without our participation.

Rationale

1. There are only two options to take: To cooperate with development of PSRO mechanisms and have an influence upon them, or to default and thereby sacrifice any influence on PSRO.
2. Without organized medicine's input, the PSRO law will be a strongly devisive factor among practicing physicians. The most logical way to bring locally-based physicians together to help designate PSRO areas, and effect them, is by using the Michigan State Medical Society. If MSMS is not involved at state and local levels, there will be the most significant erosion of organized medicine since its inception. HEW is directed to bypass organized medicine, and if this is accomplished there may be *no* organized medicine as we know it. We must, therefore, become and remain involved.
3. Although there is no place in the law for organized medicine per se, in fact, HEW has no other easy way to reach practicing physicians.
4. MSMS is the only major organization concerned with the practice of medicine as it affects the physicians and patients in Michigan.
5. MSMS can prevent pockets of non-coverage and disadvantageous designation of areas.
6. The AMA House of Delegates at its Scientific Convention in Cincinnati in November, voted to assume "a dominant role of leadership in the implementation of the PSRO program. . ."

(Continued on next page)

An advisory committee is being formed by AMA to undertake that task.

7. The MSMS House of Delegates has in various actions, notably authorization to implement "Medical Programs, Inc.," assumed a position favoring peer review.
8. Peer review is in fact operative in Michigan hospitals through hospital utilization committees. It is likely that these utilization committees will continue to function in PSROs.
9. A PSRO large enough to provide administrative and informational assistance for itself will be too large to efficiently review medical practice; a PSRO small enough to provide efficient medical review will be too small to provide itself the necessary administrative and information assistance it needs.
10. Other kinds of organizations are waiting to take on the task. The American Hospital Association, American Association of Medical Colleges, state government agencies, and others are willing and anxious to become the vital juncture between local PSROs and the Federal Government, if state medical societies fail to do so. We should further note that some local areas may form their own PSROs without state society involvement. *Therefore quick consideration is required.*

Assumptions of Possible MSMS Role

The Committee suggests that MSMS can do the following in the best interests of both its membership and the PSRO objective:

1. It can provide administrative services. Through its membership it has access to approximately 90 per cent of practicing physicians in Michigan; it is the only organization which has the loyalty and confidence of the overwhelming number of physicians; and it is the only organization with the unique knowledge of Michigan physicians, their problems and their strengths as they affect the various parts of the state.
2. It can provide balanced informational services. Whereas there are extant a number of data banks on Michigan medical care delivery, no other source of information is qualified to speak for physicians only. MSMS can draw upon various sources, digest and disseminate information to PSROs in a sensible and usable form for the benefit of PSROs, physicians and patients.
3. MSMS can provide to the battery of local PSROs projected in Michigan an overall, or state-wide, viewpoint, which no local organization can do.
4. MSMS can in turn provide information to the members of the State Professional Review Organization Council which will strengthen the hand of the physician members.
5. MSMS can serve as an expediter between local PSROs and HEW, and as an advocate for its members.
6. Initially, MSMS can draw together and coordinate the efforts of component societies in preparing a proposal for designated PSRO areas.

Summary

The Committee on Governmental Medical Care Programs urges The Council to accept its recommendation to take the initiative in planning PSROs in Michigan because:

1. MSMS is committed to peer review through action of the House of Delegates.
2. PSRO through PL 92-603 is the law of the land.
3. The AMA is committed to a leadership position in an advisory capacity.
4. MSMS can strive to achieve equity for component societies in dealing with the government.
5. Finally, unless organized medicine (AMA, MSMS and all Michigan's component medical societies) becomes aggressively involved, PSROs, by bypassing organized medicine, can be the most destructive instrument yet devised against medicine as we know it.

Caveat

The Committee warns that should The Council accept the Committee recommendation, it should appreciate that the magnitude of the PSRO program is such that if MSMS is involved, it must be involved to a vast degree.

Recommendation

That MSMS take the initiative to develop a state-coordinated locally-operated plan for Professional Standards Review Organizations in Michigan.

President's page

Doctors must join efforts to further improve health care

John J. Coury, MD
MSMS President

How do you measure how effectively a health care system meets the needs of the people?

Medical care in the USA excels if you use the following standards as measurements:

- General health, growth and development.
- Improved life expectancy.
- Eradication of infectious diseases.
- Elimination of contagious disease such as poliomyelitis, tuberculosis, typhoid fever and tetanus.
- Advances of medical and surgical techniques for the early detection, treatment and cure of heart disease, stomach ulcers, cancer and other killer diseases.

There is much evidence that the quality and quantity of medical services in the USA is now at an all-time high, and compares favorably with the situation in any other nation in the world. It should be recognized also that mortality and morbidity rates in the United States are at the lowest levels ever, and the situation in this respect is continuing to improve.

Now shifting from this tack, consider the reasons why the present health care system is not perfect in our nation. Some people who need care go without it because they cannot afford it, or because it simply isn't available to them, or because they don't know how to obtain it, or because they lack adequate education to use what is available. Some people living in remote rural areas or urban ghettos have no readily available access to the health care system. In addition, government health programs fall short of providing full health care.

Physicians and medical societies have been too willing to take all the blame for weaknesses in the health care picture. Certainly doctors, nurses, dentists, others know that many outside factors influence the nation's health. We need to point out these related factors more than we have been doing and physicians need to work with others to actively seek improvements. I am talking about poor housing and sanitation, obesity, alcoholism and drug abuse, cigarette smoking, home and auto accidents, poor diet practices, inadequate health education in the schools, suicides and homicides.

Doctors must tackle these health-related problems and then set about to find better ways to expand our good system of medical care to those who do not now receive the benefits or services. Without discarding the traditionally-good aspects of the present system we must fill the gaps.

One of the five major projects of the MSMS communications efforts this year is to help people get medical care. The working plans have been sent to each component society and pilot projects are being started. The project obviously is not a one-shot effort for only 1973 but it focuses attention now on the need to be progressive and aggressive.

People in Michigan and the nation, in my opinion, have the best medical care ever available anywhere. Our goal must be to really provide this very fine care to everyone no matter where they live in Michigan. That is a mighty big assignment.

I strongly urge you to join in the efforts of your component society, of your hospital staff, of your medical specialty associations — and in the new efforts of MSMS and the AMA to provide the best of medical care for everyone.

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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

The AMA and PRSOs/Continued

g. To develop continuing education programs through which physicians can secure for themselves and their patients the full benefit of the application and refinement of PSRO;

h. To develop and maintain liaison with appropriate governmental agencies involved in the PSRO program as well as other third parties and agencies involved and interested in the effective and efficient delivery of health care services;

i. To develop and disseminate information about P.L. 92-603 as the basis for a constituent society developing an understanding of the law;

j. To reaffirm that the AMA be a strong advocate in support of the medical profession whenever regulations or administrative policy interfere with the practice of medicine and instruct the state association when the federal register is contrary to the spirit of the law;

k. To furnish the Council on Legislation material that may be used for future bills embracing the type of peer review already approved by the AMA;

l. To monitor the effect of PSROs on the quality of medical care and report their findings to each future meeting of the House and from there to the state associations.

This is a big order—perhaps the most important charge to any committee since the Medicare regulations were formulated (HIBAC).

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Warnings: Use during pregnancy is to be avoided.

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2. *Lactic Acidosis:* This drug is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, periodic determinations of ketones in the blood and urine should be made in diabetics previously stabilized on phenformin, or phenformin and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH, and the lactate-pyruvate ratio. The drug should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis.
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Adverse Reactions: Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake.
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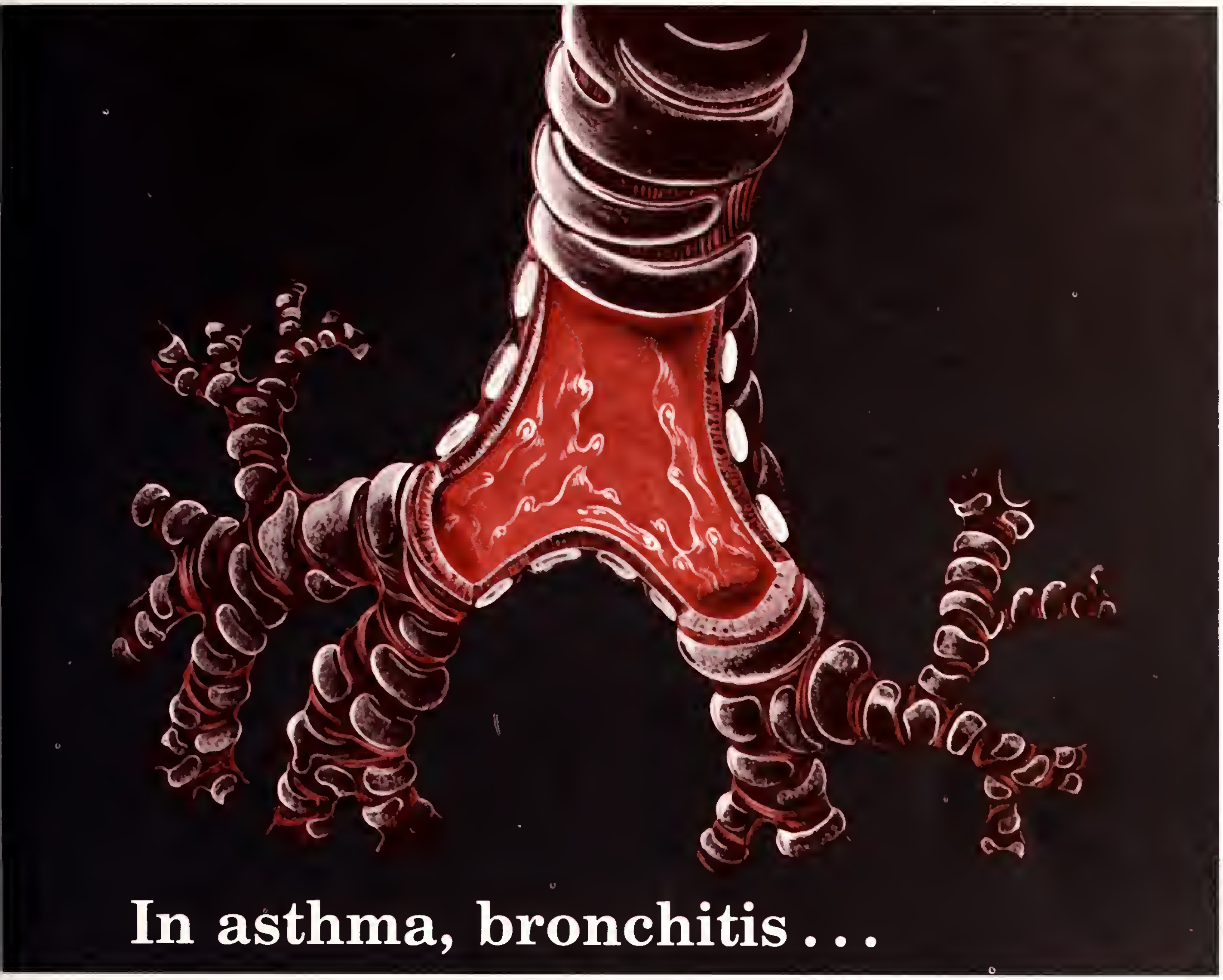

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References: 1. Itkin, I. H., Am. Fam. Phys. 4:83, 1971. 2. Feinberg, S. M., Consultant Sept., 1971, pg. 32. 3. Bookman, R., Ann. Allerg. 29:367, 1971.

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Doctor Sweeny reports:

Michigan's AMA delegation succeeds with several convention resolutions

(Following are excerpts from the detailed report about the AMA meeting in Cincinnati made to the MSMS Council by Donald N. Sweeny, Jr., MD, chairman of the MSMS delegation to the AMA.)

The House of Delegates of the AMA met in Cincinnati, Ohio, November 26-29, to consider 65 resolutions and 59 reports of its trustees, commissions and councils. Your Michigan Delegation, consisting of John Coury (Port Huron), Otto Engelke (Ann Arbor), Paul Lahti (Royal Oak), John Moses (Detroit), Robert Rice (Greenville), George Slagle (Battle Creek), Joseph Witter (Bloomfield Hills), and Donald Sweeny, Chairman (Detroit); alternate delegates Donald Anderson (Iron Mountain), Vernon Bass (Saginaw), James Danforth (Grosse Pointe), Brooker Masters (Fremont), Richard McMurray (Flint), Marjorie Peebles-Meyers (Detroit), Robert Prophater (Bay City) and Frank Walker (Grosse Pointe), met daily in caucus prior to official meetings of the House.

Each was active at reference hearings and each carried responsibilities in shepherding the five Michigan resolutions through to successful consideration by the House.

MSMS introduced a resolution that would direct the AMA to support legislation to provide that a physician shall be responsible for the care and treatment of all patients who arrive at the emergency service and that such responsibility may be satisifed in whatsoever manner a physician deems to be correct and in the best interest of the patient. The intent was to change the language of the "Conditions of Participation for Hospitals" under Title 18 (Medicare). The resolution was approved and referred to the Board of Trustees for implementation.

MSMS introduced a resolution about rehabilitative care legislation. The resolution was approved in content by amendment to read: "Resolved that the AMA actively support enactment of appropriately worded federal legislation to provide benefits for chronically ill and disabled patients who require medically necessary and productive rehabilitative care with such needs being determined by physicians."

In the area of medical malpractice, the MSMS resolution asked the AMA to endorse and encourage state medical associations to sponsor legislation in their respective states which would require the posting of a suitable security cash deposit or bond as guaranteed payment by the plaintiff of all costs and reasonable attorney's fees incurred by the defendant in medical malpractice action if the plaintiff fails to recover any damages. The California law provides for the filing of bonds in two instances: 1) related to a bond to secure court costs only, and 2) including security to cover costs and reasonable attorney's fees in that element of the plaintiff's suit seeking punitive damages. The latter amendment has not become operative and is under consideration of the court as to constitutionality.

"Smallpox immunization" was the heading for another MSMS delegation resolution. The confusion which followed the admonition of the Department of Public Health and the AMA in mid-1971 anent smallpox immunization was emphasized and partially clarified by this action of the House of Delegates. The AMA now suggests that virologists seek new methods of immunization against smallpox which produce less reaction and greater length of immunization; that physicians, while strictly observing contraindications, have the option to immunize against smallpox whether or not immunization is required by the U.S. Public Health Service or other countries; and that the AMA continue to encourage all medical and hospital personnel to be vaccinated

Doctor Sweeny

periodically to show a high degree of protection against smallpox. This point of view is more rational than the policy enunciated in June, 1971. The documentary evidence presented as an addendum by the Illinois Delegation (Resolution 9) is worthy of distribution through the usual channels.

Another resolution proposed by Michigan dealt with the present method of acquainting delegates to the House with candidates for offices by using breakfast caucuses. Strongly debated pro and con, the matter was referred to the Council on Long Range Planning and Development for inclusion in its report on the organization and procedures of the House of Delegates.

Resolution 12 from the MSMS asks for better dialogue and understanding between the deans of U.S. medical schools and the AMA. The House was agreeable to continued efforts to reduce "town-gown" problems but it was reminded that two-thirds (74 out of 111) of the M.D. deans of the American medical schools are dues-paying members of the AMA—a better percentage than among physicians at large in the United States. That better inter-relations still could be developed not only with the *deans* but also with the *faculties* was emphasized.

The Michigan delegation requested the establishment of a section on emergency medicine within the AMA. The close relationship of the American College of Emergency Physicians and the MSMS is well known to us in Michigan. The meteoric growth of emergency medicine as a recognized medical service was documented. The intent of the Michigan resolution was endorsed and the Board of Trustees was urged to act favorably for the formation of a Section on Emergency Medicine.

The Michigan delegation was proud to present the invitations of the MSMS, the Wayne County Medical Society and state and county and city officials to the Board of Trustees, to hold the Clinical Convention in 1977 in Detroit.

The Michigan delegation agreed to present the name of John Moses, MD, to The Council of MSMS for nomination as a candidate for election to the Council on Medical Education in June, 1973.

(Note: detailed articles about the AMA House decisions re PSRO, medical education, hospital matters, AMA operations, etc., have appeared in the *American Medical News*—Managing Editor)

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Vitamin B_{12} and Folate Assays:

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Depletion of Vitamin B_{12} is the paramount feature of pernicious anemia and is a pathogenetic factor in most cases of the megaloblastic syndrome. In true pernicious anemia or following total gastrectomy, the B_{12} deficiency arises from a selective absorption defect caused by the absence of intrinsic factor, a glycoprotein secreted in normal gastric juice. Vitamin B_{12} deficiency may also occur from various other causes, most important of which are the various malabsorption syndromes. Serum levels are a reliable indication of Vitamin B_{12} nutrition when liver disease and myeloproliferative disorders can be ruled out. Hepatocellular damage, especially viral hepatitis, can cause release of Vitamin B_{12}-binding protein into the blood, thus facilitating an increase in Vitamin B_{12} levels.

Serum B_{12} is decreased in:

- Pernicious anemia
- Malabsorption syndrome
- Gastrectomy
- Lesions of the small intestine—ileal resection, blind loop, strictures, diverticulosis, anastomosis, regional enteritis
- Nutritional vitamin deficiency
- Pregnancy
- *Diphyllobothrium latum* infestation

Serum B_{12} is increased in:

- Acute and chronic myelogenous leukemia
- Polycythemia vera
- Myeloid metaplasia
- Liver disease—cirrhosis, hepatitis

Megaloblastic anemias of infancy and pregnancy are frequently the result of folate deficiency. Infants with various pathological conditions are predisposed to folate deficiencies. Rapidly growing tissues and intensive hematopoiesis to meet the steadily expanding blood volume increase the demand for folate. Reserves are low even in healthy infants, especially those fed with heated cow's milk. Any infection may produce a clinical deficiency state.

Although some infants with megaloblastic anemia respond to small doses of Vitamin B_{12}, this therapeutic "cross-effectiveness" has not yet been fully explained and treatment with the "wrong" vitamin is potentially dangerous. In megaloblastic anemias cytological examinations cannot establish the specific etiology. Since diagnosis by therapeutic trials is cumbersome, the investigation of serum levels of both compounds is indicated.

Borderline serum folate levels are difficult to interpret in those patients with little or no hematologic changes. In such cases the measurement of red blood cell (RBC) folate levels (where B_{12} deficiency has been excluded) will provide an accurate quantitative guide to the severity of folate deficiency. When RBC folate is subnormal the indications are a severe depletion of the folate content of both the hemopoietic and liver cells.

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Radioimmunoassay:

A major diagnostic methodologic breakthrough and preliminary experience with TSH assay

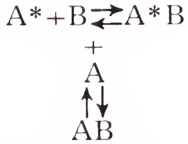
By Joel I. Hamburger, MD
Southfield

Doctor Hamburger writes of the subject of his paper, "Radioimmunoassay is an important new procedure which will rapidly achieve preeminent status in clinical laboratory assay work in the general hospital setting. It seems to me that it is important for the physicians of Michigan to have exposure to the general principles of radioimmunoassay as well as some indication of the usefulness of one of the more important radioimmunoassays which is becoming available in more and more institutions. It is my hope that this report will serve in this fashion."

The low plasma concentration of many peptide hormones makes their assay by biological or chemical techniques impractical. They cannot be reliably distinguished from other plasma proteins which are present in concentrations 100 million times as great. The development of radioimmunoassay by Berson and Yalow[1] therefore may be referred to properly as a major breakthrough in diagnostic methodology. This technique permits the sensitive and specific quantitation of substances which are present in extremely minute concentrations. Radioimmunoassay takes advantage of the high degree of specificity of an immunological reaction between a peptide hormone as the antigen, and a bio-synthesized antibody.

The general principle of radioimmunoassay can be illustrated as a set of competing reactions:

A* = Free hormone labeled with a radioactive tracer
B = Antibody
A = Unlabeled hormone (in standards or unknowns)
A*B = Labeled hormone antibody complex
AB = Unlabeled hormone antibody complex



$$\begin{array}{c} A^{*} + B \rightleftarrows A^{*}B \\ + \\ A \\ \uparrow\downarrow \\ AB \end{array}$$

Labeled hormone is bound by its specific antibody to form a labeled antigen-antibody complex. Unlabeled hormone in plasma or other solutions will compete with the labeled hormone for binding by the antibody, displacing from the antibody a portion of the labeled hormone which is proportional to the quantity of unlabeled hormone added to the system. The displaced labeled hormone is then separated from the bound hormone—antibody complex by one of several methods, and is assayed in a scintillation counter. Reference to a standard curve prepared from the assay of varying known concentrations of the hormone permits the determination of the concentration of hormone in the unknown.

The injection of peptide hormones into experimental animals, particularly rabbits or guinea pigs, leads to the production of antibodies quite regularly. Hence radioimmunoassay was initially limited to the measurement of these substances. Compounds with a molecular weight below 1,000 are not immunogenic, hence are not suitable for radioimmunoassay directly. However, they may be combined with protein carriers, acting as haptens, and antibodies may then be produced to the conjugate.[2] As a result, the application of radioimmunoassay has been greatly extended to include many compounds of importance in medicine. Table 1 is only a partial list of substances for which

Scientific articles

Doctor Hamburger is associated with the Northland Thyroid Laboratory of Southfield.

TABLE 1
Radioimmunoassayable Compounds

- Aldosterone
- Angiotensin II
- Calcitonin
- Colon Cancer Antigen
- Cortisol
- Cyclic AMP
- Digitoxin
- Digoxin
- Follicle Stimulating Hormone
- Gastrin
- Glucagon
- Growth Hormone
- Human Placental Lactogen
- Insulin
- Luteinizing Hormone
- Parathormone
- Prostaglandins
- Renin
- Testosterone
- Thyroid Stimulating Hormone
- Thyroxine
- Triiodothyronine
- Vitamin B_{12}

radioimmunoassay may be employed. Any list will necessarily be incomplete before it is published, because new assays are being developed continually.

The radioimmunoassay of thyroid stimulating hormone (TSH) may be considered exemplary of the usefulness of this technique. Prior to the development of radioimmunoassay the serum TSH concentration (STSH) could be measured only by biological assay. This method is suitable only for a research facility, and the data was far from precise. We shall report our experience with TSH radioimmunoassay to alert physicians to the general importance of this new technique, and to indicate its specific applicability in thyroid disease.

Method

The double antibody radioimmunoassay for TSH described by Odell, et al., has been employed in our laboratory.[3] Human TSH (HTSH) for the reference standard was supplied by the Medical Research Council (MRC Standard A). Rabbit antihuman thyrotropin antiserum (RA), and purified human thyrotropin (for labeling with radioactive iodine) were obtained from the National Pituitary Agency. Goat antirabbit gammaglobulin (G-ARGG) was obtained from Antibodies Inc., David, California. Human TSH was labeled with ^{125}I (HTSH*) by the method of Hunter and Greenwood.[4]

In the assay an unknown containing HTSH is added to HTSH*-RA complex, the HTSH displacing a proportion of the HTSH* from RA. After equilibrium is reached, G-ARGG is added, precipitating the antibody bound TSH, labeled and unlabeled. The liberated HTSH* which remains in solution is removed from the system by aspiration after washing, leaving only the precipitated bound TSH, a proportion of which is labeled with ^{125}I. The precipitate is then counted in a scintillation counter, and the activity compared to a standard curve constructed from assays of solutions containing known concentrations of HTSH. The serum concentration of TSH (STSH) is reported in microunits of the international reference standard per ml (μU/ml).

Serum Thyroxine determinations (T_4) were done by the Abbott Laboratory resin sponge modification of the method of Murphy and Pattee. The normal range in our laboratory is 3-6.5 μg%, expressed as T_4 iodine, not corrected for extraction efficiency.

TSH tests were done by giving TSH (Armour Laboratory product), five units intermuscularly, followed by a tracer capsule of ^{131}I, 12 to 24 hours later, with an uptake determination 12 to 24 hours after the tracer capsule administration. A normal response in our laboratory is an increase of at least 10% above baseline values (e.g. baseline 24-hour radioiodine uptake 5%, uptake after TSH 15%).

Results

Three hundred twenty patients with a variety of thyroid problems were studied to provide us with an assessment of the utility of the TSH assay. In most reports euthyroid patients have values less than 10 μU/ml. We studied 158 patients who were euthyroid by clinical and laboratory evaluations. Forty-three patients with no evidence of thyroid disease had STSH values between 2 and 14.5 μU/ml, average 4.9. Only three patients had values in excess of 10 μU/ml. Forty-nine patients taking thyroid hormone for hypothyroidism and judged to be euthyroid had STSH values between 2 and 11.5 μU/ml, average 5.0. Three euthyroid patients after thyroidectomy had values of 2, 5, and 11 μU/ml. Five euthyroid patients following a bout of subacute thyroiditis, had values between 2 and 7 μU/ml, average 4.5. Fifty-eight patients who were euthyroid after ^{131}I therapy for hyperthyroidism were studied. Of this group, 44 patients had STSH values between 2 and 9.5 μU/ml, average 3.2. However, 14 patients had values between 10.5 and 33.5 μU/ml, average 15.9. Those with elevated values were indistinguishable on clinical and laboratory evaluation from those with normal values.

Nineteen hyperthyroid patients were studied, two of whom had iatrogenic hyperthyroidism from excess administration of thyroid hormone. As regularly observed by others, STSH values were within the lower normal range, 2-8.5 μU/ml, average 3.2. Fifteen hyperthyroid patients whose disease was controlled by antithyroid drugs (Lugol's solution in 2) had values between 2 and 7 μU/ml, average 5.2.

Seventy-two hypothyroid patients without goiter were studied. Seventeen had primary hypothyroidism (not resulting from surgery or ^{131}I therapy) with STSH values between 11 and 250 μU/ml, average 96. Twenty-one patients with hypothyroidism after thyroidectomy had values between 12 and 250 μU/ml, average 80. All six patients studied six weeks after total thyroidectomy for cancer had values greater than 100 μU/ml. Twenty-eight patients with hypothyroidism after ^{131}I therapy had values between 2 and 250 μU/ml, average 62. Six of these patients had values less than 10 μU/ml. Serum thyroxine values ranged from 1.2 to 2.8 μg%. Four of these patients developed their hypothyroidism within the initial six weeks following ^{131}I therapy, hence were only hypothyroid for a matter of a few weeks at most. Another patient became hypothyroid five months after ^{131}I therapy, but six weeks earlier was still distinctly hyperthyroid, hence the duration of the hypothyroidism was also a period of less than six weeks. The final patient had discontinued the thyroid hormone which had been ordered for hypothyroidism following ^{131}I therapy (Synthroid 0.2 mg daily) two weeks prior to testing, was hypothyroid clinically and had a serum thyroxine value of 1.6 μg%. Four of these six patients had STSH values of 2 μU/ml, one had 7 μU/ml and the final patient had 9.5 μU/ml.

Five patients with hypothyroidism after subacute thyroiditis had STSH values of 15-172 μU/ml, average 57.2 μU/ml. One patient was overtreated with Propylthiouracil and had a value of 250 μU/ml.

Sixty-one patients with diffuse goiter were studied. Thirty-five were euthyroid with STSH values less than 10 μU/ml. Twenty-five patients had elevated STSH values, of whom 18 had thyroid function tests within normal limits, but STSH values between 11 and 32 μU/ml, average 18. Seven were hypothyroid and had STSH values between 31 and 126 μU/ml, average 75 μU/ml. One patient had a relapse of hypothyroidism and goiter after discontinuing thyroid hormone two weeks previously. The serum thyroxine was 1.7 μg%, however, the STSH value was only 5 μU/ml.

There were two euthyroid patients with recurrent goiter after surgery, both of whom had STSH values of 2 μU/ml.

Eleven diffuse goiter patients with elevated STSH values (11-102 μU/ml, average 33.5 μU/ml) and evidence for hypothyroidism from mild to severe were given TSH tests. Seven did not respond to parental TSH, but four did, including one with a serum thyroxine of 0.8 μg% (The T_3 value was 28% with the normal range being 25-35%, hence the low T_4 value was not the result of a marked decrease in thyroxine binding protein). The radioactive iodine uptake increased from a baseline value of 18 to a post-TSH value of 28%. Nine other diffuse goiter patients were clearly euthyroid and had normal STSH values (2-9.5 μU/ml, average 4.3 μU/ml). However, four of the nine failed to respond to TSH testing.

Comment

It has been claimed that radioimmunoassay for STSH is a sensitive and reliable indicator of primary hypothyroidism (5-7). However, our results, and those of others indicate that an elevated STSH value need not mean hypothyroidism.[8,9] Elevated values may be seen in patients with diffuse goiter secondary to Hashimoto's disease, iodine deficiency, iodine induced goiter, after surgery or radioiodine therapy to the thyroid, or radiation therapy of an extensive degree to the neck area.[8,9] After surgery[10] or radioiodine therapy,[9] elevated values for STSH may be temporary. As a result of increased THS stimulation T_4 output may be restored, with a subsequent fall in STSH to normal levels. On the other hand, persistent elevations of STSH, even in euthyroid patients, particularly those with goiter, or previously treated with ^{131}I or surgically, would seem likely to indicate incipient hypothyroidism. How often and how soon this further deterioration of thyroid function occurs requires further study. Response to TSH testing does not reliably separate euthyroid patients from those with hypothyroidism, regardless of STSH levels.[9]

It seems clear that some patients with primary hypothyroidism may not have elevated STSH. This may be seen early in the development of hypothyroidism. It has been shown that when thyroid hormone is discontinued in patients with primary hypothyroidism the PBI falls before the STSH rises.[11] Preliminary studies in only a few such patients showed a lag of several days in the rise of STSH.[11] However, the delay in STSH elevation would seem to be a function not only of the duration of hypothyroidism, but also the degree of involvement. In all six of our patients studied six weeks after total thyroidectomy STSH levels greater than 100 μU/ml were observed. It seems likely that the patients with hypothyroidism after ^{131}I who failed to have increased STSH did not have athyreosis. In fact, four of these patients recovered from hypothyroidism in the succeeding six weeks, while the other two remained hypothyroid and developed elevated STSH values. Thus it would appear that the severity as well as the duration of hypothyroidism are factors in the magnitude, and even the presence of an elevated STSH.

Conclusions

1. Radioimmunoassay provides a relatively sensitive and specific method for the measurement of STSH, as well as the concentrations of many other important compounds present in biological fluids.
2. An elevated STSH, although characteristic of primary hypothyroidism, may be seen in some euthyroid patients. In conjunction with goiter, this finding may indicate an increased likelihood of progressive deterioration in thyroid function. Elevated STSH may be seen transiently after ^{131}I or surgery, with restoration to normal as recovery of T_4 output takes place.
3. Persistent elevation of STSH in euthyroid patients after ^{131}I may indicate a greater potential for late onset hypothyroidism, but the frequency with which this complication will ensue requires further study.
4. Normal STSH levels may be seen early in hypothyroidism, particularly if the impairment of thyroid function is less than total.
5. The magnitude of the STSH elevation, and the rapidity with which it develops, relate to the severity and duration of the hypothyroid process.

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A transport service for sick newborn infants in Michigan

By Dietrich W. Roloff, MD
Robert C. Borer, Jr., MD
Ann Arbor

Establishment of newborn intensive care units (NICU) in medical centers across the country has been an important contribution to the intact survival of critically ill newborn infants. Increasingly, physicians use regional NICU for sick newborn infants born in hospitals in which the number of deliveries does not justify the complex technical facilities and additional personnel necessary to operate a NICU.

However, a major impediment toward full utilization of regional NICU has been the difficulties associated with the safe transport of infants from one hospital to another. Frequently it has been decided that the critical and unstable condition of an infant precludes a conventional ambulance transport and that skilled personnel able to intervene in crises during the transport are not available. The difficulty of preventing temperature loss in conventional incubators which cannot be operated in ambulances has also further discouraged transfer of infants to regional NICU.

To surmount these problems medical centers have established newborn transport services using newly available transport incubators. Such a Newborn Transport Service was established by the Department of Pediatrics of the University of Michigan Medical Center in Ann Arbor in 1971; our initial experiences are the subject of this report.

Equipment

After a transport incubator* was purchased we insured the compatibility of its oxygen and electrical connections with those of the vehicles of two local ambulance companies. This was accomplished by the Pediatric Respiratory Therapy Department which has continued to be responsible for the mechanical operation and servicing of the transport incubator. This incubator can be operated on 115 Volt AC current or a 12 Volt DC current from either the automobile generator or its own battery; the 24 Volt DC power source available in aircraft can also be used.

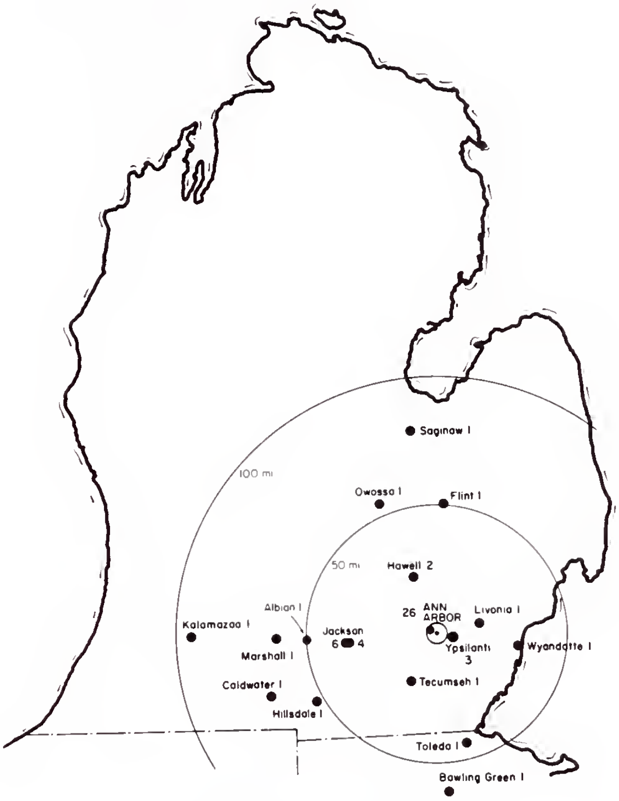

FIGURE 1: Geographical distribution of the hospitals from which newborn infants were transported to the Neonatal Intensive Care Unit at the University of Michigan Medical Center. Figures next to city names indicate the number of infants transferred.

It is the intention of the Newborn Transport Service to enable a team of skilled personnel to support the infant throughout the entire transport. Therefore, a pack of emergency equipment was assembled. One group of items consists of drugs and medical equipment and is contained in a fishing

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*Ohio Medical Products, Madison, Wisconsin

Doctor Roloff is an instructor, and Doctor Borer is assistant professor, Department of Pediatrics and Communicable Diseases, University of Michigan Medical Center.

TABLE 1: Medical Equipment for Newborn Transport Team.

Equipment:
Stethoscope
Bulb syringe
De Lee suction trap
Cutdown set
Umbilical artery catheters (3½F and 5F)
Suction catheters (5F, 6F, 8F, 10F)
3-way stopcocks, connectors
Needles (#21, 22, 25)
Butterfly needles (#21, 23, 25)
Solution administration set
Adhesive tape
Silk suture (4-0)
Sterile gloves
Knife blades
Syringes (1, 5, 10, 20 ml.)
Feeding tubes (5F, 8F)
Dextrostix
Urine bags
Thermometer
Alcohol sponges
Tubes for collecting blood specimens

Drugs and solutions:
Sodium Bicarbonate 8.4% (30 ml vial)
Glucose 50% (50 ml vial)
Calcium Gluconate 10% (10 ml vial)
Heparin 1000 units/ml (10 ml vial)
Phenobarbital 65 mg/ml (10 ml vial)
Diazepam 5 mg/ml (2 ml amp)
Nalorphine 0.2 mg/ml (2 ml amp)
Methylprednisolone 40 mg/ml (2 ml vial)
Digitoxin 0.2 mg/ml (1 ml amp)
Furosemide 10 mg/ml (2 ml amp)
Epinephrine 1:10,000 (10 ml vial)
Isoproterenol 1:5,000 (1 ml amp)
Glucagon 1 mg/ml (1 vial with solvent)
Water for injection (30 ml vial)
Normal saline (30 ml vial)
Lidocaine 1% (30 ml vial)
10% glucose in water (500 ml bottle)
5% glucose in 0.2% NaCl (250 ml bottle)

TABLE 2: Respiratory Therapy Equipment for Newborn Transport Team.

Oxygen flowmeter with nipples
Connectors for ambulance oxygen tanks
Portex endotracheal tubes (2.5-4.5 mm)
Stylettes
Laryngoscope with premature and infant blades
Spare bulbs and batteries for laryngoscope
Magill forceps
Oropharyngeal airways
Oxygen hood
Humidifier for oxygen
Oxygen tubing
Resuscitation masks (sizes 0, 1, 2)
15 mm adaptors
Continuous positive pressure set

tackle box (**table 1**). The second group of items consists of equipment necessary for oxygen therapy and respiratory support; it is contained in a shoulder bag (**table 2**). After use, the medical equipment is replenished by the nurses in the NICU; the Pediatric Respiratory Therapy Department is responsible for the maintenance of the oxygen and respiratory support equipment.

A portable battery-operated EKG monitor* with an oscilloscope is added to the equipment when the team departs. This monitor is an invaluable help to the team in assessing the infant's condition throughout the transport as it has been found that even in good ambulances it is very difficult to do reliable auscuetation continuously.

Organization

The Newborn Transport Service is available to any physician requesting it by calling a special telephone number which has been communicated to physicians in the area. After a call has been received the ambulance company is notified and the on-call transport team assembles.

The team consists of an experienced physician (a Fellow in neonatology or a senior pediatric resident or a staff neonatologist), a neonatal intensive care nurse, and a pediatric respiratory therapist.

The team leaves within 15 minutes after a call has been received. Upon arrival at the requesting hospital, they serve as consultants to the infant's physician and execute necessary diagnostic and support procedures. The facilities of the transferring hospital are used as much as possible, in particular the X-ray and laboratory services.

Particular attention is given to the screening of the infant's blood sugar level by the Dextrostix method[1] and intravenous glucose (0.5 g/kg) is administered for levels below 30 mg %. Similarly, acidosis is treated with sodium bicarbonate (1.0 mEq/kg) if the pH is less than 7.25. If the infant is found to be hypothermic, it is allowed to warm up, if at all possible, before the initiation of the transfer itself (in the case of a hospital less than a mile away from the UMMC exceptions are made when the infant's temperature is low because of the brief duration of the transport).

The maternal history and the history of the infant up to the time of the transport have been recorded by the staff of the referring hospital on previously distributed forms. Samples of maternal blood and the infant's cord blood, if available, are obtained. The parents are made aware of the infant's condition and are given the opportunity to see their infant.

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*Datascope 850, Datascope Corporation, Saddle Brook, New Jersey

Ventilatory assistance can be given manually with a self-inflating bag* attached either to a face mask or an endotracheal tube. The latter is the preferred method for continuous assistance during longer transports. This has the additional advantage that continuous positive airway pressure (CPAP) can be used throughout the transport. Enough oxygen is carried to supply one infant for at least three hours at 10 L/minute. The battery will power the incubator for two to six hours (depending on the ambient temperature) if the electrical power from the ambulance were to fail. As soon as the infant's condition is sufficiently stable, the transport team leaves for Ann Arbor after the NICU has been appraised by telephone about the infant's condition and any anticipated need for special procedures or consultations.

During the transport the infant is observed constantly both visually and with the EKG monitor. Procedures such as suctioning or temperature measurements are carried out as needed. The ambulance driver is advised to ensure as smooth a ride as possible back to Ann Arbor, while speed is more emphasized on the trip to the requesting hospital.

Results

During the 10-month period from October 1, 1971 to July 31, 1972 the services of the Newborn Transport Team were requested by 30 physicians from 20 hospitals for 60 patients. On one occasion the team was recalled while enroute because the infant had died. Two infants died at the referring hospital with the team in attendance. Thus 57 infants were admitted to the NICU from the Newborn Transport Service. This includes three infants transported from the Ann Arbor airport to which they had been flown by air ambulance from Marquette (2) and Alpena (1), respectively. The location of the other 18 referring hospitals is shown in Figure 1. The following tabulations (see also table 3) are based on our experience with the 57 infants transported in 56 trips (there was one pair of twins).

The age of admission to our NICU ranged from 1½ hours to 53 days. However, transports for infants over one week were infrequent as 53% of the patients arrived at under 12 hours of age. The observation that 44 % of the infants had a birth weight of over 2500 g demonstrates that the Newborn Transport Service was not considered as a conveyance for premature infants only. The majority of the infants were critically ill. In addition to those already intubated by their physicians, our teams placed endotracheal catheters in nine cases prior to transport; umbilical vessels were catheterized nine times, glucose and/or sodium bicarbonate were administered in 10 instances. One infant underwent needle aspiration of a pneumothorax.

During the transport 39 infants (68%) required some form of respiratory therapy: 18 were spontaneously breathing oxygen concentrations between 40% and 100%; another 18 infants needed assisted ventilation. Glucose was given to 3 infants intravenously when they had evidence of hypoglycemia. No major treatments or resuscitative efforts were necessary during any transport and no death occurred during any trip, though one infant with severe malformations died within minutes after arrival at our NICU. All other infants survived for at least three hours following the completion of the transport.

The temperature of the infants on arrival when compared with that at the referring hospital had remained unchanged within normal limits (36.1°—37.8° C) in 29 instances; it rose from normal to above 37.8° C in three cases and in four cases it remained elevated (these infants were found to have infections). The temperature dropped on three occasions to slightly below 36.1° C; a more significant drop to 35.0° C was experienced once. An initially low temperature which could not be corrected during the transport was observed in 14 infants; this was seen in the very small infants transferred locally when the transport lasted only a few minutes. In three infants the initial hypothermia was corrected during the transport.

The overall survival rate was 58%. Of the 33 survivors four were transferred back to the referring hospitals for the final phase of their recovery. The return transports were accomplished in the transport incubators and the infants were accompanied by a nurse.

In order to evaluate the efficacy of the Newborn Infant Transport Service as a safe means of making intensive newborn care available to outborn infants we compared the 57 transport infants with 51 inborn infants admitted to our NICU from our own obstetric service during the same time (table 3). While there were differences in some

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*Hope Bag, Ohio Medical Products

TABLE 3: Characteristics of 57 outborn infants transferred by the Newborn Transport Team and of 51 inborn infants transferred to the Neonatal Intensive Care Unit.

	Outborn infants N=57				Inborn infants N=51			
	No.	(%)	No. survived	(% survived)	No.	(%)	No. survived	(% survived)
Birthweight:								
1000 g	6	(10%)	1	(17%)	9	(18%)	1	(11%)
1000-1499 g	8	(14%)	2	(25%)	8	(16%)	4	(50%)
1500-1999 g	8	(14%)	4	(50%)	12	(24%)	9	(75%)
2000-2499 g	10	(18%)	8	(80%)	11	(22%)	9	(82%)
2500 g	25	(44%)	18	(72%)	11	(22%)	8	(73%)
Age at admission:								
24 hours	36	(63%)	21	(64%)	47	(92%)	27	(57%)
1-7 days	18	(32%)	7	(39%)	4	(8%)	4	(100%)
7 days	3	(5%)	2	(67%)	0	—	—	—
Survivors			33	(58%)			31	(61%)
Diagnosis:								
prematurity only	2	(4%)	2	(100%)	2	(4%)	2	(100%)
respiratory distress syndrome	24	(42%)	11	(46%)	25	(49%)	14	(56%)
asphyxia	4	(7%)	3	(75%)	2	(4%)	1	(50%)
other respiratory disease	3	(6%)	3	(100%)	2	(4%)	2	(100%)
hyperbilirubinemia	4	(7%)	4	(100%)	7	(14%)	4	(56%)
malformations	9	(16%)	5	(56%)	2	(4%)	1	(50%)
endocrine disturbance	1	(2%)	0	0	5	(10%)	5	(100%)
congenital heart disease	6	(10%)	3	(50%)	2	(4%)	1	(50%)
other	0	—	—	—	1	(2%)	0	0
Treatment after admission:								
respirator	24	(42%)	6	(25%)	25	(49%)	11	(44%)
continuous positive pressure	6	(10%)	5	(83%)	4	(8%)	4	(100%)
exchange transfusion	1	(2%)	1	(100%)	8	(16%)	4	(50%)
surgery	6	(10%)	4	(67%)	3	(6%)	1	(33%)

criteria, e.g., birth weight and age at admission, the distribution of the diagnoses was similar. The comparison shows that the overall survival rates were not significantly different from each other.

Comments

The importance of well-organized infant transport services was first recognized when special nurseries for premature infants were established in the 1930's. Large cities (e.g., New York, Chicago) provided infant carriers to ambulance companies conveying infants to premature centers. These carriers were baskets or aluminum boxes with compartments for hot water bottles. Later, they were fitted with attachments for oxygen hoses. Only rarely were skilled personnel in attendance during the transport.

The change from premature nurseries to neonatal intensive care units in the 1950's and 1960's and, in particular, the feasibility of respirator treatment for newborn infants suggested transfer for many infants for whom hitherto chances of survival had been equally poor in small hospitals or large medical centers.[2,3]

This led to the establishment of various types of newborn transport services. In one form a special van, equipped as a miniature NICU, is operated by the medical center and dispatched to the requesting hospital.[2,4,5] More commonly, cooperative arrangements between hospitals and private ambulance companies, such as the one we have described above, have been used.[2,6,7,8] Aircraft have also been employed successfully in infant transport projects.[2,9,10]

The important factor, regardless of the organizational details, is the continuous attention by trained personnel to the infant during transport between its home hospital and a NICU. The survival rates for infants thus transported have been similar to that in our experience.[3,5,6] We believe that specially equipped vans with their cost in excess of $12,000 are too expensive unless their usage is very high. The described organization of a newborn transport service is flexible and economical. The ambulance companies charge for this service the same fee as for other ambulance runs. The cost of the initial equipment is approximately $2,300.

The radius of action of a newborn transport service is dependent with other factors on the length of time for which personnel can be released from their other duties at a NICU. To date we have limited our response to a distance of 100 miles. The majority of our transports have been within 50 miles. In general, we have not found it practical to utilize aircraft because of a longer response time, limited capacity for carrying personnel, noise, and unpredictable flying conditions. It should be borne in mind that all fixed-wing aircraft and many helicopter patient transfers necessitate the use of two ambulances for ground transportation between hospitals and airports.

We believe that newborn transport systems such as the one used by us and other NICU's in Michigan constitute an integral part of the regionalization of intensive care for newborn infants. Experience elsewhere has shown that neonatal mortality in hospitals which make regular use of referral NICU's can be lowered to almost that of obstetric services with in-house neonatal intensive care units.[11]

Summary

Over its initial 10 month period the Newborn Transport Service at the University of Michigan Medical Center was used to transfer 57 sick infants to the neonatal intensive care unit. The infants were transported in transport incubators in commercial ambulances. They were accompanied by a physician, a nurse and a respiratory therapist. This team could provide full support to the infants with suitable equipment. Ultimate survival was achieved for 33 infants (58%).

Update

As of Dec. 31, 1972, one hundred eighteen transports have been carried out in the manner described. In addition to the communities shown in **Fig. 1**, infants were transported from hospitals in the following cities: Adrian, Bay City, Midland, Monroe, Mount Pleasant, Trenton, Wayne and West Branch.

Acknowledgements

We wish to thank the many individuals who helped establish our Newborn Transport Service: Mr. Bruce Steinbach, ARIT and Ms. Mary Vaessen, ARIT of the Pediatric Respiratory Therapy Department; our Head Nurses Barbara Lanese, RN and Margaret Coltre, RN, and our Fellows William Scott, MD and Samuel Sefton, MD. We are grateful for the assistance from Mr. Stuart Williams, Assistant Director of University Hospital. We also want to express our appreciation to the referring physicians who allowed us to participate in the care of their patients. We are indebted to the Department of Anesthesiology for the loan of the Datascope 850 monitor.

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Perinatal tips

By Paul M. Zavell, MD
Detroit

The following case from the files of the Wayne County Medical Society Perinatal Mortality Committee is presented as an aid in continuing education.

Maternal

This was the fourth pregnancy of a gravida IV, para II, 40 year-old white clinic mother with O+ blood type.

Her first pregnancy ended in a miscarriage at about two months. Both the second and third pregnancies resulted in term infants six pounds, 3 ounces and six pounds, 10 ounces. Each infant became jaundiced in the first few days of life due to AO incompatibility. However, neither required any specific treatment.

At about the 32nd week of this—her fourth pregnancy—leakage of amniotic fluid began and continued intermittently until birth of the infant four weeks later. She was seen soon after the initial onset of amniotic fluid leakage by her clinic obstetrician who felt bed rest at home was all that was necessary. This suggestion was followed *poorly* at home because of the many household demands made (her children were aged 2 and 4 years respectively).

At about 36 weeks following lifting of the 2-year-old child up into his crib for his afternoon nap, the mother noted a sudden gush of vaginal fluid slightly blood stained and soon thereafter she began to have lower abdominal cramps.

She called her clinic doctor who advised her to come to the hospital if the cramps and vaginal leakage did not quickly cease with strict bed rest. Following his advice she noted only minimal intermittent cramps and only slight leakage for the next eight hours while in bed. However, definite labor pains started when she got up from her bed to go to the bathroom.

She went to the hospital where four hours and 33 minutes later a four pound, two ounce, white, male infant was born by frank breech delivery.

The clinic obstetrician noted "low implantation of the placenta with minimal abruptio present." The mother had had regular prenatal visits. Her VDRL was negative at three months when she was first seen. Blood pressure and urinalysis done at each of her visits were normal. At the time of the delivery it was noted the mother had a mild head cold and 100° (O) temp. She was given no treatment while in the hospital and recovered uneventfully.

Fetal

Following birth this four pound, two ounce white male infant seemed normal at his hasty physical in the delivery room by the obstetrician. Cord blood studies showed: A+, Direct Coombs and ABO negative. However, despite a warmed isolette it was one to two hours after birth before the body temperature could be brought above 97.6°. Thereafter there was no trouble with temperature regulation until the morning of the third day.

The infant was checked by the pediatric intern about three hours after birth. His physical was completely normal.

Sucking from birth had not been very good so that the infant was gavaged, first with glucose water and then with Similac with iron formula. At 24 hours of age a slight tinge of jaundice was noted by the staff physician as the only abnormality. Bilirubin studies showed total bilirubin of 7.3 mgm% with 1.2 mgm% direct and 6.2 mgm% indirect. This was explained away by him as due to "mild dehydration" and glucose water was given tid between feedings of the diluted formula.

By 48 hours of age a repeat physical exam by the intern revealed only a slightly lethargic, slightly jaundiced infant. Otherwide, CNS and other parts of the physical exam seemed normal. Bilirubin at 48 hours was only 9.8 mgm% total (8.5 mgm% indirect). This was now considered "physiologic" rather than "due to mild dehydra-

(Continued on page 150)

Doctor Zavell is chairman, Neo-Natal and Hospital Care Commitee, Michigan Chapter, A.A.P., and chairman, Perinatal Mortality Study Committee, Wayne County Medical Society.

Streptococcal Pharyngitis:

A Comparison of Parenteral Lincomycin And Oral Clindamycin Therapy With a Similar Penicillin Regimen

By Gary Ruoff, MD
James D. Panzer, MD, PhD
W. H. Atkinson, MA
Kalamazoo

Several studies have been done which show that oral lincomycin[1,2,3,5,6,8] or clindamycin[4,7,8,9] result in excellent efficacy in eradicating streptococci from the throat of patients with Group A β-hemolytic streptococcal pharyngitis. These comparative studies showed lincomycin or clindamycin to be as effective as penicillin and in certain studied tending to be superior. These studies, with one exception in which benzathine penicillin was used, were concerned with a comparison of oral medication. However, many physicians do not use benzathine penicillin or a strictly oral regimen, but prefer to initiate therapy with a single injection of procaine penicillin followed by oral penicillin therapy. It was the purpose of this study to investigate the comparative efficacy of this type of penicillin regimen as compared to a similar lincomycin/clindamycin regimen in which a single injection of lincomycin would be followed by oral clindamycin therapy.

A second aspect of the study which had no relation to drug treatment groups was the investigation of how many asymptomatic subjects harboring streptococcal organism could be found in the families of those patients presenting for treatment.

Material and Methods

Subjects were selected from a private general practice patient population. All subjects were evaluated clinically, a throat culture taken, and patients put into the study only if the presence of β-hemolytic Group A streptococcal organisms could be demonstrated. Subjects were placed on medication using a randomized, double-blind technique with a given subject assigned to one of two antibiotic regimens consisting of:

> A single injection of lincomycin hydrochloride equivalent to 600 mg. of base Stat. followed in six hours by oral therapy of clindamycin palmitate suspension according to the package insert dosage recommendations.
>
> **OR**
>
> A single injection of aqueous potassium penicillin G, 600,000 units Stat., followed in six hours by oral therapy of potassium penicillin G suspension according to the package insert dosage recommendations.

In each group medication was continued so that the patient received a total of 10 days therapy. Patients returned for clinical and microbiological (throat culture) evaluation at seven, 14 and 30 days after the start of treatment. In addition, all siblings of a patient put in the study were called in for throat culture and asymptomatic carriers determined.

Results

The treatment groups are described in Table 1 and the results are given in Table 2 (subjects completing study).

One hundred fifty-five patients completed the study. It can be seen that the groups were relatively similar in average age, aver-

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Doctor Ruoff is in private family practice at the West Side Family Medical Center, PC, Kalamazoo. Doctor Panzer is medical research chief of the Infectious Disease Products Division of the Upjohn Company, where Mr. Atkinson is a medical marketing associate in infectious disease research.

TABLE 1: Description of Treatment Groups of Subjects Completing the Study.

	Lincocin IM → Cleocin Palmitate (Oral)	Penicillin G IM → Penicillin G (Oral)
No. completing study	79	76
No. males	45	37
No. females	34	39
Age (Average)	6.7	7.5
Average initial temperature	100.0	100.5
Average streptococcal infestation of initial culture*	many	mod.
No. with diagnosis of:		
Pharyngitis without exudate	43	33
Pharyngitis with exudate	14	28
Tonsillitis without exudate	2	4
Tonsillitis with exudate	7	10
Scarlet Fever	3	0
Adenitis	10	1

*Rare only a countable number of colonies of β-hemolytic streptococcus
Few<25 colonies of β-hemolytic streptococcus
Mod. 25-50 colonies of β-hemolytic streptococcus
Many > 50 colonies of β-hemolytic streptococcus

age initial temperature, and in number of patients completing study 79 (Lincocin®IM → Cleocin® Palmitate)* and 76 (penicillin G IM → oral). The average streptococcal infestation of initial cultures was many (4+) in the Lincocin → Cleocin Palmitate group and moderate (3+) in the penicillin G IM → oral group.

The average number of days with temperatures was the same (one day) in both groups. However, bacteriological failure rates were slightly higher in the Lincocin IM → Cleocin Palmitate group than in the penicillin G IM → oral group. This difference was not statistically significant and may be related to the fact that the clindamycin subjects had more streptococci in their initial cultures.

Side effects were not a problem, and in no instance did a side effect result in discontinuance of study medication. Reported side effects in the subjects that completed the study were as follows:

	Lincocin IM Cleocin Palmitate	Penicillin G → Penicillin G (oral)
No. of patients reporting side effects:	19	16
Frequency of side effects reported:		
Loose and frequent stools	9	5
Skin rash	7	6
Loss of appetite	7	6
Abdominal pain	4	4
Vomiting	2	2
Nausea	1	2

Subjects in the study represented 104 families consisting of 336 siblings. When these siblings were tested for the presence of β-hemolytic streptococcal organisms in their throats (although they were asymptomatic), 87 of them were found to have positive throat cultures (26%). Of the 104 families represented by the patients presenting, asymptomatic disease was found in at least one sibling in 57 of the families (55%) and two siblings in 20 of the families (22%).

Discussion and Conclusions

The results found in this study confirm

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*Lincocin® is The Upjohn Co. registered trademark for Lincomycin hydrochloride. Cleocin® is The Upjohn Co. registered trademark for clindamycin.

TABLE 2: Clinical Results of Subjects Completing Study.

	Lincocin IM ⟶ Cleocin Palmitate (Oral)	Penicillin G IM ⟶ Penicillin G (Oral)
Average No. days with fever	1	1
No. of subjects with positive cultures at day 7	0	3
No. of subjects with positive cultures at day 14	3	1
No. of subjects with positive cultures at day 30	8	3
No. cured	68	69
No. failed	11	7
Percent cured	84%	91%

those found in other studies comparing various penicillins with the lincomycin/clindamycin group of drugs. In the light of these data it is evident that Lincocin IM → Cleocin Palmitate is a safe and effective alternate to the use of injectable penicillin G followed by penicillin oral in streptococcal pharyngitis.

The value of testing the asymptomatic siblings of patients presenting for treatment is evident when one considers that the organism will be present in half of the families so concerned and that two or more siblings will be asymptomatic carriers in one-quarter of the families. This high incidence may explain the frequent troublesome problem of recurrence where certain individuals in a family seem to continually have episodes of the disease. It is possible that these individuals are extremely susceptible and easily acquire the organism from their less sensitive siblings who do not get the disease clinically, but serve as reservoirs for the organism.

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(Continued from page 146)

tion," as thought earlier. There was no concern with ABO incompatibility.

Things changed little until the morning of the third day when the infant was noted to have 101° (R) temperature, seemed more lethargic and vomited once. One hour later the infant had a prolonged generalized "shivering episode" followed by frequent twitching. The intern called the staff physician's office but could not contact him. He gave the infant phenobarbital 10 mgm IM but this didn't help. The infant expired shortly thereafter.

An autopsy was done that revleaed E. Coli sepsis with involvement of the CNS meninges and lungs. Culture of blood after death grew out E. Coli.

Perinatal Committee Comments

1. Expectant therapy at 32 weeks in a case of amniotic fluid leakage may be justified but by 36 weeks the infant is usually large enough to be delivered if necessary. The mother should have been seen immediately in the hospital to rule out any complication (such as prolapse of the cord for example).
2. Communication between obstetrician and pediatrician was poor here when it should have been good (especially with premature rupture of membranes, mother with URI symptoms and the infant definitely premature).
3. Jaundice in the first 24 hours of life noted clinically is only rarely physiologic. When such occurs other causes (blood incompatibility, infection, syphilis, cytomegalic inclusion disease) must be considered.
4. Poor temperature control, poor sucking, jaundice at 24 hours, lethargy all should have clued those in charge to the possibility of infection, especially in a premature. Early initiation of antibiotics could have been life-saving here.
5. In premature rupture of membranes the committee wishes to make these points:
    - a) the development of amnionitis can be a serious threat to both mother and baby
    - b) the incidence of amnionitis may on occasion be increased by the use of "sterile" vaginal examinations
    - c) antibiotics in the mother are of value when labor begins or when infection is obvious but they are of questionable (or no) value prophylactically
    - d) any infant born after *prolonged* ruptured membranes should have adequate cultures taken (cord blood, surface of placenta, gastric contents, ear, axilla, or groin and blood). A spinal tap with culture is encouraged.
    - e) any infant born after ruptured membrane (regardless of duration) who shows any signs suggestive of sepsis (see #4 above—also include irritability) should have appropriate cultures done immediately followed by initiation of antibiotic therapy (penicillin and Kanamycin).

Legal problems in critical care units

By Martin L. Norton, MD
Dayton, Ohio

The very designation of special care areas as Critical Care, Recovery Room, Coronary Care or Intensive Care units implies certain legal, moral and ethical responsibilities. These responsibilities include the best possible medical care supported by biomedical instrumentation that is both safe and effective. This is the legal standard of care defined by the medical profession itself with the assistance of the biomedical engineer.[1] Failure to meet these standards exposes the medical and engineering practitioners as well as the entire hospital organization to charges of negligence. Indeed, the very absence of such units in the year 1973 could be so interpreted.

Concepts of implied warrantee, products liability, strict liability and reliance mandate an inter-disciplinary approach to the problem. Not the least of its many facets is the need of on-site testing of equipment, specialized maintenance, and constant attention to the needs of safety and effectiveness requiring the skills of the trained bioengineer.

A review of case law demonstrates a progression at an ever-increasing tempo of liability principles expanding the responsibilities of physicians, products engineers, manufacturers, hospitals and health related personnel.[2]

This presentation is geared to practical, functional and reasonable approaches to the solution of these problems.

Special care areas suggest provision of the best care available with the most up-to-date philosophies and instrumentation and specially trained personnel. Thus, when confronted with the question of the "standard of care," one would be inclined to answer "only the finest." The medical profession has itself indicated the parameters to be met. The public is entitled to rely on this implied representation, and any deficit (extant or potential) can be looked on as a failure of the "duty" to perform "as advertised." Standard of care is a term often referred to by attorneys, defined with apparent clarity, but in essence variable according to the state of knowledge and practice at the moment. At one time this term was used in relation to area practice, the common procedures used in the specific area in which the physician practices. This "locality rule" is rapidly becoming passe. Now, a physician is judged, as are his co-professionals on the health team, by the professional practices in similar health care communities. Having disposed of this aspect, what is "standard of care"? It is that level of professional competence which would be provided by other competent up-to-date health professionals under the circumstances of the specific case.[3]

You will note that this is a poorly defined statement. As it is used it does not include innovative diagnosis and therapy. It does mean that each and every one of the health care team must involve himself in continuing education activities to be alerted to and familiar with changes in his areas of practice. He does not have to accept all that is purportedly new and in vogue, but he must thoroughly consider the

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changing patterns of practice and reasonably and logically accept or reject the specifics of those changes.

Products Liability/Implied Warrantee[4]—refers to the responsibility of the designer, manufacturer and provider for instrumentation and relata. It is based on the fact that the defendant-manufacturer or provider has access to information about the safety and function of the product that is not usually available to the patient—or—even if it were, he (the patient) does not have the technological background to understand its implications. (Some of you will recognize here an analogy to the concepts of "informed consent." It is a subclassification of the strict liability category. One area is the use of equipment not site-tested and maintained, such as defibrillators, pacemakers and ventilators, etc. Usually this equipment is purchased by the hospital and used by medical personnel. Responsibility for failure lies with the legal principle of joint-and-several liability based on implied warrantee. The hospital, medical personnel and manufacturer share the burden in varying degrees. Obviously, purchase, testing and maintenance by the hospital provide the greatest protection. We still have the responsibility of not accepting at face value the mere provision of equipment. This imposes on the medical staff the responsibility to participate in decision making aspects of administrative factors in this area.

The Restatement of Torts[5] states—"one who sells any product in a defective condition unreasonably dangerous . . . is subject to liability . . . for physical harm thereby caused to the ultimate user or consumer . . . The rule applies to any manufacturer . . . dealer . . . or distributor."

The criterion in many courts seems to be in terms of establishing responsibility for marketing a product that *might* cause injury. The full effects of this social philosophy are clearly evident in assessing the consumer's (i.e. patient's) right to rely upon the benefits of available safety features, devices, guards and accessories. One court specifically stated that a company may be charged with knowledge of engineering safety know-how. The term "company" can also be interpreted to mean "hospital." Now, legislative bodies such as the Ribicoff Committee are extending the safety concept to include performance to a desirable therapeutic end-point.

The question often arises—if I do not use instrument X in the care of my patients, am I risking legal action? The answer can only be—if this instrument is customarily used during the management of this type of case—*yes*. An example would be failure to use a cardiac monitor in a coronary care unit on a patient with a recent myocardial infarction.

The complexity of monitoring now extends to arterial pressures, blood gas analyses, oxygen concentrations actually being delivered, tidal volumes, temperatures, humidity, and in obstetric units—Doppler-effect evaluation of fetal factors. It also includes the installation of such available safety devices as fail-safe controls on anesthesia and ventilatory equipment, and Fenwall bag blood pumps to obviate the hazards of air-embolization while pumping in blood under pressure, at rapid rates.

Similarly, failure to test monitoring and other electrically powered units regularly for leakage, grounding and potentiometer-like build-up of charges certainly falls within these concepts. Further down the line can be found negligence in choosing equipment from the viewpoint of established standards, electrical codes, installation of isolation transformers or floating-grounds, et cetera.

What is required of us—by the standards we ourselves have instituted? 1. Use biomedical instrumentation to monitor physiologic parameters, and to support life functions . . . . 2. Constant vigilance and re-evaluation of all instrumentation to assure both

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Medico-legal

The AMA's Citation *newsletter, prepared by the AMA Law Department, lists the following cases involving health personnel in Michigan. Persons interested in obtaining more information on individual cases may write MSMS headquarters.*

"Self-incrimination in disbarment proceedings" Michigan Supreme Court, April 13, 1970 from *The Citation,* Vol. 25, No. 12, Oct. 1, 1972

"Medicare benefits ruled not insurance benefits" Michigan Court of Appeals, March 24, 1972 from *The Citation,* Vol. 26, No. 2, Nov. 1, 1972

"Last treatment rule applied in malpractice suit" Michigan Court of Appeals, April 25, 1972 from *The Citation,* Vol. 26, No. 3, Nov. 15, 1972

safety and effectiveness of such equipment.[6] .... 3. Survey comparable institutions for knowledge of their practices, and changing practices .... 4. Keep records ... in the *opperable* units regarding testing results, preventative maintenance, etc. This information must be made readily available to the *clinically* functioning people who bear the final responsibility ... not hidden in the filing cabinet of the remote hospital pseudo-engineer's office. 5. New equipment must have failure-mode analysis data made available to those using the equipment, and must be tested and retested for function and specifically evaluated as to whether it accomplishes what it purports to accomplish. No equipment should even be purchased without such a review by competent hospital employed bioengineering personnel.

The nurse presents special areas for enquiry.[7] What are the hazards of the "extended nurse's role"? What can she do in the absence of the doctor?

This question really expresses our uncertainty with regard to legal liabilities incurred by physician's assistants, nurse-clinicians, anesthesiologists-assistants, and the like. We have no definitive answers. We can only speculate, based on our experiences with other paramedical personnel since there is no current case precedence. The conclusion we draw is that the nurse clinician is an agent of the physician, ie. *respondeat superior.* Under the principles of Agency Law she is responsible individually for her actions where there is evidence that she deviated from accepted practice and/or specific instructions. This implies that she *must* have written instructions, specific in nature to delineate the parameters of her activity—yet broad enough to permit her to accomplish her stated purpose. This must, therefore, provide for those contingencies—including the absence of the doctor, which could or should be foreseen. In essence, she can go no farther than her instructions (written or verbal).

However, where do the physician—and hospital administration—stand?

Under the borrowed-servant doctrine[8] the physician was held liable for a hospital employee who failed to read the label on the bottle and handed the physician the wrong medicine. The administration resulted in injury to the patient. The court stated "the fact that the duty of seeing ... mistakes do not occur is delegated to others does not absolve the doctor from responsibility for their negligence."[9] In the instance ... responsibility can be devolved on ... who has control of the (employee) at the critical time. In this vein, the hospital administration (including trustees) can also be responsible for members of their staff even though they are not contractually hired by the institution. This is the ruling of the now-famous Darling case[10] ... For the balance, the physician bears full responsibility not only for the nurse's or inhalation therapist's actions, but for those very instructions we previously discussed. 2. What are the implications of a nurse giving a drug or an amount of a drug which she thinks is deleterious to the patient? What if the doctor insists that he will take the responsibility?

The clear cut legal answer is—that the very *belief* of possible harm on the part of the nurse can be used against her. It is an "admission of guilt" should she, still harboring such belief, give the drug or dosage. The doctor cannot—repeat NOT—"take the responsibility". She is still liable. If he wishes to give the dosage he himself should give it,—and be ready to answer for his actions should harm ensue.

3. How much do written policy and procedures protect non-physicians? Answer—very little—if the non-physician knows, or should have known of potential harm. On the other hand, it does have great evidentiary value, if the instructions are prudently drawn. She would then be liable only for deviating to such extent as another would not have done. Example—instructions say "No patient is to receive more than 20 mgm Morphine in a single dose q3h." The nurse gives the dosage in 2½ hours to a terminal patient. This could be interpreted as being within judgemental limits. However, if she gave this dose every 30 minutes—this would be negligence beyond judgemental error.

Another question we are often presented with relates more to the physician than the "RN". What are the implications of shutting off respirators—or—not giving cardiopulmonary resuscitation? This is one of the most difficult problems I've been faced with. There is no pat answer. We obviously are not talking about the terminal patient, jaundiced, with inoperable metastatic carcinoma, incontinent and in coma. The real difficulty lies with Mrs. Gotrocks, who may be a donor for a transplant. Aside from the problems of consent, the consensus of opinion is that the Harvard Ad Hoc Committee's criteria must be met—i.e. areflexic, comatose, and a flat EEG pattern. Unfortunately, the viability of the organ to be transplanted may be embarrassed by awaiting such criteria. However, that is another problem still to be dealt with effectively.

Also, Mrs. Deprived Society—who has been comatose for weeks, but still has reflexes and an EEG pattern. It is manifestly incumbent on us not to quit here. There have been cases of patients comatose for months—who recover. True—they have been few and very far between.

What is most difficult is the question of who makes the decision to stop therapeutic measures. The memory of the Nazi era remains too fresh in my memory to glibly accept the committee concept, or to relieve any individual of responsibility. This must remain in the purview of the conscience of every physician—and *he must be subject to review and enquiry regarding his ultimate decision . . . . And to answer for the consequence of that decision.*

Next—What about the inhalation therapist? In Michigan, current statutes[11] give the pharmacist jursidiction not only over drugs, but also over any equipment by way of which medication may be introduced. Also, the inhalation therapist is the only non-MD, non-RN, non-pharmacist who in practice "compounds and administers" medication without statutory support or licensure. The current drive for registration or licensure reflects this dilemma. However, by virtue of the concept of "*respondeat superior*"—the physician, hospital or whoever has control over the professional acts of the therapist bears full responsibility for whatever occurs.

Another area of great concern is that of infection. This includes cross infection from equipment as well as direct person-to-person transmission. Interest waxes and wanes according to the publicity given to the problem. Lerner stressed the role of ventilators in regard to pseudomonas and pyocyaneus organism contamination. The use of special techniques for cleansing inhalation therapy equipment including acetic acid soaks depends upon the flora anticipated. Disposable equipment, wherever possible, aids in preventing the problem. Ethylene oxide sterilization of non-disposable equipment including all ventilators adds to the possible solution. Unfortunately, in our cost-conscious environment the significant expenditures required both for the sterilizer, and the duplication of equipment required to allow proper sterilization and ventilation have been a disadvantage of this approach.

The use of separate patient rooms (preferably with full transparent walls) have helped somewhat, but still have the disadvantage of somewhat hindering patient care—from the logistics of direct nurse-patient contact. On the other hand the open ward approach potentially leads to the greatest risks of cross patient-to-patient contamination. Of course, the greatest offender here is the physician—who has forgotten or not learned (in our current laissez-faire medical school teaching) about Pasteur, Lister and a few of my other predecessors.

Lest you think this is much ado about nothing—the theme of the American Association for Contamination Control meeting on May 8-10, 1972 in Palo Alto, California was "Reduction of hospital acquired infections and legal liability."

In summary,—I have merely introduced for your awareness, areas of moral, legal and ethical responsibility—imposed by society through its representatives—the courts. We must meet this challenge for the benefit of our patients. Pandora's box has opened! Whither from here?

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The views of general practitioners and psychiatrists on psychiatric teaching in medical school

By Hugh C. Hendrie, MD
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To say that medicine is in a state of flux is now almost a cliche. The era inaugurated by the Flexner report with its emphasis on "scientific" medicine is rapidly coming to an end. In a report commissioned by the American Medical Association, Millis suggests a different direction for medical education. Teaching hospitals, he states, should now "prepare many more physicians than now exist who will have the desire and the qualifications to render comprehensive continuing health services."[1]

Many medical schools, including Wayne State University's, have reflected this new orientation and have expressly stated as their goal the production of "primary care physicians." With this aim in mind, our department in conjunction with other disciplines has begun to consider what psychiatric skills and knowledge should be taught to the medical student. One major criticism of academic and specialty medicine, however, has been its separation from the great bulk of clinical practice. Are academic physicians necessarily the most competent judges of what constitutes essential knowledge for the doctor involved in "primary care"? Perhaps valuable advice might come from those physicians who at the moment most closely fill the role of providing "primary care," i.e., the general practitioners.

It is the purpose of this present study to compare the views of general practitioners and faculty psychiatrists on what should be the goals in psychiatric teaching during medical school for our future primary care physicians as the first step in preparing an appropriate curriculum.

Method

A questionnaire was distributed with a covering letter to 48 members of the Department of Psychiatry at Wayne State University and to 62 general practitioners drawn at random from a central registry of physicians. The questionnaire consisting of 62 items was a slightly modified version of the one used by Walton in a prior study.[2] Each item consisted of a statement about which respondents were asked to agree or disagree.

In addition to the covering letter, the general practitioners were contacted by telephone and the purpose of the study was explained further. Forty-one psychiatrists and 31 general practitioners returned the completed forms.

The responses of the psychiatrists and the general practitioners were factor analyzed separately and together using a computer program written in Fortran. The method of analysis used was principal components solution with varimax rotation. A response of not true was scored as 1 and a response of true was scored as 2. Items were selected to construct the factors if they had a loading with an absolute value greater than 0.4.

Results

Psychiatrists

Five factors were identifiable, representing five teaching dimensions from the replies of the psychiatrists. The five factors taken together accounted for 70.86 per cent of the variance. In order of importance they were:

1. *Systematic Descriptive Psychiatry* (Table 1) Accounts for 21 per cent of the total variance. This cluster stresses the importance of teaching students descriptive psychiatry with emphasis on correct diagnosis and classification. It suggests that most of the teaching time should be spent on the major psychoses and on patients who present in psychiatric hospitals.

Doctor Hendrie is associate professor, Department of Psychiatry, Wayne State University, while Doctor Hudson is with the Department of Internal Medicine, Providence Hospital, Southfield. Doctor Grisell is associate professor, Department of Psychology, Wayne State University and Division Head, Computing Laboratory, Lafayette Clinic, Detroit.

2. *Behavioral Assessment* (Table 2) Accounts for 15.72 per cent of the total variance. The chief emphasis here is on teaching the skills of personality evaluation to medical students. The importance of teaching psychology as a behavioral science is stressed as is the importance of a careful mental status examination. The psychiatrist's role should be presented as that of treating major illness.

3. *Psychological Perceptiveness* (Table 3) Accounts for 13.43 per cent of the total variance. In this component the psychiatrists stress the importance of teaching the student to be aware of his own psychological process (two items) and to be sensitive to the nuances of interpersonal relationships in his handling of patients (two items). To accomplish this they would emphasize close personal contact between the student and his teachers, and they suggest group interaction as a good method of teaching.

4. *Student—Teacher—Patient Interaction* (Table 4). Accounts for 10.81 per cent of the total variance. This component concerns teaching methods. It suggests most time should be spent by the student with his patients or teaching in small groups with his instructors. It de-emphasizes the formal systematic lecture system.

5. *Biological Psychiatry* (Table 5) Accounts for 9.89 per cent of the total variance. Here emphasis is placed on the teaching of psychopharmacology and physical methods of treatment. Psychological approaches on the other hand are de-emphasized.

General Practitioners

In general it was more difficult to identify and name the general practitioner factors. This may be related to the difficulty of one member of specialty completely understanding the views of another. However, five components were identifiable representing 75.65 per cent of the total variance. In order of importance, they were:

1. *Ability to Handle Psychiatrically Disturbed Patients in General Practice* (Table 6) Accounts for 23.42 per cent of the total variance. General practitioners seemed more concerned with the setting in which the future physicians will practice. From this point of view, teaching should concentrate on the clinical psychiatric disorders that general practitioners will encounter. Teaching is best conducted in an outpatient unit. Students should know how to differentiate major from minor mental disorders and should know about psychiatric treatment procedures (for correct referral?). There should also be concern about student's own responses in interpersonal processes and in his dealing with emotionally disturbed patients. Taken together this factor seems to be a concise presentation of the skills a general practitioner should possess. He should: a) feel comfortable with emotionally disturbed patients b) be sophisticated in interpersonal relations c) be able to make accurate diagnosis and correct referrals on the psychiatrically disturbed patients he meets within his practice.

2. *Role of Psychiatrists as Experts in Interpersonal Relations* (Table 7) Accounts for 16.52 per cent of the total variance. This resembles in many ways the negative pole of the second factor in the psychiatrists' questionnaire. The importance of the psychiatrist's role as an expert in interpersonal relations is stressed. It is not essential to teach students descriptive psychiatry nor to present psychology as a behavioral science. Systematic examinations using psychiatric patients are not necessary.

3. *Teaching of Interpersonal Process* (Table 8) Accounts for 13.51 per cent of the total variance. In this component, considerable emphasis is given to the teaching of interpersonal process. Psychiatrists should teach how psychotherapeutic skills can be used to relieve interpersonal difficulties. Teaching should be carried out on nonpsychiatric patients. There should be close contact between student and teacher, and group interactional techniques could be utilized to make the student aware of his own interpersonal responses. However, students should also be taught the importance of diagnosis and systematic classification in psychiatry.

4. *Integrated Approach to Psychological Disturbance* (Table 9) Accounts for 12.74 per cent of the total variance. Here emphasis is given to explaining both physical and psychological factors in each patient in an integrated way. Teaching should be done on general hospital patients and the students should be exposed to the basic sciences of neurophysiology and neuropharmacology. The patient should be viewed in the traditional medical model, not necessarily as a part of a disturbed family.

5. *Clinical Knowledge of Major Mental Disturbances* (Table 10) Accounts for 10.46 per cent of the total variance. This factor in many ways resembles factor 1 in the

psychiatrist's responses. Here emphasis is given to teaching about the major psychiatric disorders which is given more prominence than teaching minor disorders or teaching psychological perceptiveness.

Discussion

Examination of the factors derived from the answers of the psychiatrists and general practitioners suggests a considerable difference in the hierarchy of objectives in the two groups.

The psychiatrist's aims in teaching fit closely the traditional model of the specialty of psychiatry.

First and foremost, students should be well grounded in careful systematic descriptive psychiatry, using patients with major psychiatric disturbances. In three of the five factors, a scientific approach to psychiatry and the study of behavior is emphasized. Factors three and four do recommend another goal, that of teaching psychological perceptiveness, and suggest the best method of obtaining these results. However, in contrast to the general practitioners, the psychiatrists do not suggest that teaching be carried out on any other than psychiatric patients.

The general practitioners, on the other hand, are more concerned with the setting of the future students' practice and of the importance of tailoring the type of teaching the students should receive to meet this goal. Thus the first factor emphasizes the need to teach students how to manage psychologically disturbed patients in general practice. The "scientific" role of the psychiatrists tends to be de-emphasized; rather, psychiatrists are seen as primarily experts in interpersonal relations. In almost all of the factors, the importance of teaching with nonpsychiatric medical and surgical patients is stressed.

Both groups, however, seem to agree on the importance of close contact between the student and his teacher during his medical school career.

These discrepancies between the aims of the psychiatrists and general practitioners were seen also when the answers of the two groups were combined, factor analyzed, and the mean scores of the groups were compared. As an illustration, the first cluster (accounting for 22.58 per cent of the total variance) is shown **(Table 11)**. In this factor where emphasis is placed on systematic descriptive psychiatry, psychiatrists scored significantly higher than general practitioners. (Psychiatrists mean score +3.99, General Practitioners mean score +3.16, $P < 0.0001$)

A study such as this does not, of course, answer the question as to which approach to student education is the most valid. However, at the moment, it would appear reasonable to take into consideration the objectives of both groups when designing a curriculum.

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TABLE 1
Psychiatrist's First Factor — Systematic Descriptive Psychiatry

Factor Loading	Item
0.636	Students should be well grounded in the importance of diagnosis and systematic classification for effective practice of psychological medicine.
0.576	Serious mental disorders (including mental deficiency) must be presented in detail as knowledge essential for future doctors.
0.550	On graduating, students should have been taught how to identify correctly major and minor disorders and to know about current special treatments in psychiatry.
0.487	Teaching should concentrate on the psychoses, which should be given more prominence than psychoneurotic and personality disorders.
0.413	The facts of clinical psychiatry should be taught without special concern over subjective attitudes.
−0.431	Much time should be devoted to teaching undergraduate techniques for managing cases of mild neurosis.
−0.508	Most psychiatric teaching should be with reference to general patients, and preferably it should be done on the wards of general hospitals.
−0.509	Psychiatry should be taught in all the clinical years, on patients presenting with medical and surgical complaints where possible.
−0.72	Comparatively little time should be spent on psychoses and serious psychiatric illnesses rather the student should be taught to understand all patients as people and to identify motivations of behavior.

TABLE 2
Psychiatrist's Second Component — Behavioral Assessment

Factor Loading	Item
0.692	The students should be taught that skills in personality evaluation are of wide applicability in general practice.
0.59	I place great emphasis in detailed history taking and methodical examination of mental status.
0.428	Students must be taught the methods and findings of psychology as a behavioral science.
0.424	The psychiatrist's particular medical competence should be clearly presented to students as primarily consisting of responsibility for diagnosing and treating major mental illness.
—0.463	Teaching time should be given to presentation of research techniques.

TABLE 3
Psychiatrist's Third Component — Psychological Perceptiveness

0.692	Teaching should provide the student with opportunities for gaining increased awareness of his own psychological processes.
0.691	The psychiatric teachers should accept responsibility for teaching how psychotherapeutic skills can be used to relieve difficulties which patients have in personal relationships.
0.691	The student should be taught that the family in which a case of psychiatric illness arises should be viewed as an entity for purposes of investigation and treatment.
0.521	Group interactions and techniques should be used as a teaching method to show the student his own responses in interpersonal relations.
0.482	For effective teaching the instruction must be organized to provide regular opportunities for personal contact between student and teacher.
0.479	Each group of students should have one continuing tutor.
—0.463	By seeing the effectiveness of physical treatments, the student will be helped toward a favorable attitude to psychiatry.

TABLE 4
Student — Patient — Teacher Interaction

0.691	Undergraduate students should spend more time actually interviewing psychiatric patients than being provided with factual clinical information by their teachers.
0.684	Psychiatric teaching cannot be considered adequate unless students are taught in small groups.
—0.411	The basic teaching method in psychiatry for medical students must remain the formal systematic lecture.

TABLE 5
Psychiatrist's Fifth Component — Biological Psychiatry

Factor Loading	Item
0.760	Psychopharmacology and physical methods of treatment generally are advancing so rapidly that to teach the future general practitioners psychotherapeutic skills may be unwarranted.
0.449	Teachers should present a clear cut organic or psychodynamic clinical orientation so that the two psychiatric approaches are distinct in the student's mind.
0.448	In examining students it is essential to use written essay questions.
—0.687	In the psychotherapeutic treatment he does with patients the student needs to be shown that his own hidden motivation contributes to the treatment process.

TABLE 6
General Practitioner's First Component — Ability to Handle Psychiatrically Disturbed Patients in General Practice

0.711	On graduating, students should have been taught how to identify correctly major and minor mental disorders and to know about current special treatments in psychiatry.
0.592	Teaching should concentrate on factual presentation of the clinical psychiatric disorders general practitioners will encounter most frequently in practice.
0.498	Clerkship over weeks in an outpatient psychiatric unit is desirable.
0.496	Group interactions and techniques should be used as a teaching method to show the student his own responses in interpersonal relations.
0.439	Lectures should be at a minimum and teaching should concentrate on small group seminars.
—0.404	The basic teaching method in psychiatry for medical undergraduates must remain the formal systematic lecture.
—0.450	In examining students it is essential to use written examinations.
—0.619	The facts of clinical psychiatry should be taught as in other branches of medicine without special concern over the subjective attitudes students develop about psychiatric patients and mental illness.
—0.652	By seeing the effectiveness of physical treatments, the student will be helped toward a favorable attitude to psychiatry.

TABLE 7
General Practitioner's Second Component — Role of Psychiatrists as Experts in Interpersonal Relations

0.681	The student should be enabled to grasp that the psychiatrist's most important professional

Factor Loading	Item
	skill is his understanding of interpersonal relations.
−0.425	Psychiatric teaching cannot be considered adequate unless students are taught in small groups.
−0.446	The student must be taught the techniques of psychotherapy to elicit and reduce the interpersonal problems to which neurotic symptoms are secondary.
−0.468	In examination of medical students it is important to use an oral examination.
−0.529	Description of symptoms and abnormal behavior syndromes should form the basis of undergraduate psychiatric teaching.
−0.533	Students must be taught the methods and findings of psychology as a behavioral science.
−0.666	In examination of medical students it is essential to use clinical examination of psychiatric patients.
−0.803	The psychiatrist's particular medical competence should be clearly presented to the students as primarily consisting of responsibility for diagnosing and treating major mental illness.

TABLE 8

General Practitioner's Third Component — Teaching of Interpersonal Processes

0.906	Psychiatric teachers should accept responsibility for teaching how psychotherapeutic skills can be used to relieve difficulties which patients have in personal relationships.
0.818	Psychiatry should be taught in all the clinical years on patients presenting with medical and surgical complaints if possible.
0.703	For effective psychiatric teaching, the instruction must be organized to provide regular opportunities for personal contact between student and teacher.
0.681	Students should be well grounded in the importance of diagnosis and systematic classification for effective practice of psychological medicine.
0.577	Group interactions and techniques should be used as a teaching method to show the student his own responses in interpersonal relationship.
0.529	In the psychotherapeutic treatment he does with patients, the student needs to be shown that his hidden motivations contribute to the treatment process.
−0.448	A responsibility as psychiatric teachers is to attract students into psychiatry.
−0.459	Clerkship over weeks on an inpatient psychiatric unit is strongly desirable.

TABLE 9

General Practitioner's Fourth Component — Integrated Approach to Psychological Disturbance

Factor Loading	Item
0.610	Both physical and psychodynamic factors should be explained for the student in each psychiatric case shown.
0.580	A prominent aim of teaching should be actively to counteract possible unfavorable attitudes to mental illness in the student.
0.476	Most psychiatric teaching should be with reference to general patients and preferably should be done on the wards of general hospitals.
0.441	Students must be taught psychopharmacology and neurophysiology as an essential part of their psychiatric training.
−0.461	The student should be taught that the family in which a case of psychiatric illness arises should be viewed as an entity for purposes of investigation and treatment.
−0.484	The family is the unit the student must be taught about in clinical psychiatry rather than the individual patient.

TABLE 10

General Practitioner's Fifth Component — Clinical Knowledge of Major Mental Disturbances

0.539	Teaching should concentrate on the psychoses which should be given more prominence than psychoneurotic and personality disorders.
0.519	The effectiveness of physical methods of treatment has led to psychiatry being recognized as an important medical specialty.
−0.461	Undergraduate students should spend more time actually interviewing psychiatric patients than being provided with factual clinical knowledge.
−0.484	Comparatively little time should be spent on psychoses and serious phychiatric illness — rather the student should be taught to understand all patients as people and to identify motivations of behavior.
−0.568	One direct objective of psychiatric teaching should be to contribute to the individual's self-maturation.
−0.587	A student should be given direct responsibility for the care of psychiatric patients over a period of time.

TABLE 11

Combined Group First Component — Systematic Descriptive Psychiatry

0.555	The psychiatrist's particular medical competence should be clearly presented to students as primarily consisting of responsibility for diagnosing and treating major illness.
0.512	Emphasis must be given to the importance of eliciting a history of mental illness in the patient's relatives.
0.476	Description of symptoms and abnormal behavior syndromes should form the basis of undergraduate psychiatric teaching.
0.475	Scientific methods for evaluating clinical practice critically should be presented to undergraduate students.
0.444	Teachers should present a clear cut organic or psychodynamic clinical orientation, so that the two psychiatric approaches are distinct in the student's mind.

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

MONTHLY SURVEILLANCE REPORT

CASES OF CERTAIN DISEASES
REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH
FOR THE FOUR-WEEK PERIOD ENDING DEC. 29, 1972

	1972 This 4-Week Period	1971 Same 4-Week Period	1972 Total To Above Date	1971 Total Same Date	Total Cases for 1971
RUBELLA	71	84	1,460	2,955	2,955
CONGENITAL RUBELLA SYNDROME	0	0	1	1	1
MEASLES	111	60	2,353	2,659	2,659
WHOOPING COUGH	7	5	116	140	140
DIPHTHERIA	0	1	1	1	1
MUMPS	471	528	3,729	10,748	10,748
SCARLET FEVER & STREP SORE THROAT	1,982	1,005	13,304	11,244	11,244
TETANUS	0	4	2	7	7
POLIOMYELITIS (paralytic)	0	0	0	0	0
HEPATITIS	336	347	4,322	4,828	4,828
SALMONELLOSIS (other than S. typhi)	35	41	781	691	691
TYPHOID FEVER (S. typhi)	0	0	7	10	10
SHIGELLOSIS	36	58	574	295	295
ASEPTIC MENIGITIS	20	21	266	239	239
ENCEPHALITIS	6	7	108	108	108
MENINGOCOCCIC MENINGITIS	1	4	55	64	64
H INFLUENZA MENINGITIS	8	3	81	82	82
TUBERCULOSIS	88	120	1,609	1,850	1,824
SYPHILIS	363	455	4,815	4,689	4,689
GONORRHEA	2,054	1,681	24,728	22,116	22,116

Information can be supplied by the local health department on the local incidence of disease.

*corrected total

Maurice Reizen, M.D. Director
Michigan Department of Public Health

Want to know how many typhoid cases reported in 1900?

Public Health Department has figures

A review of the statistics published from 1900-1969 by the Michigan Department of Public Health reveals some interesting trends in the incidences of reportable diseases in Michigan.

Thirteen communicable diseases have been listed in the records dating back to 1900.

They are diphtheria, scarlet fever and strep throat, smallpox, typhoid fever, whooping cough, measles, infectious hepatitis and serum, tuberculosis, meningococcal infections, poliomyelitis, syphilis, gonorrhea, and chancroid.

More incidences of measles (20,356) were recorded in 1900 than of any other of the 13 diseases. Meningococcal infections had the smallest number reported (654) among the 13 in 1900.

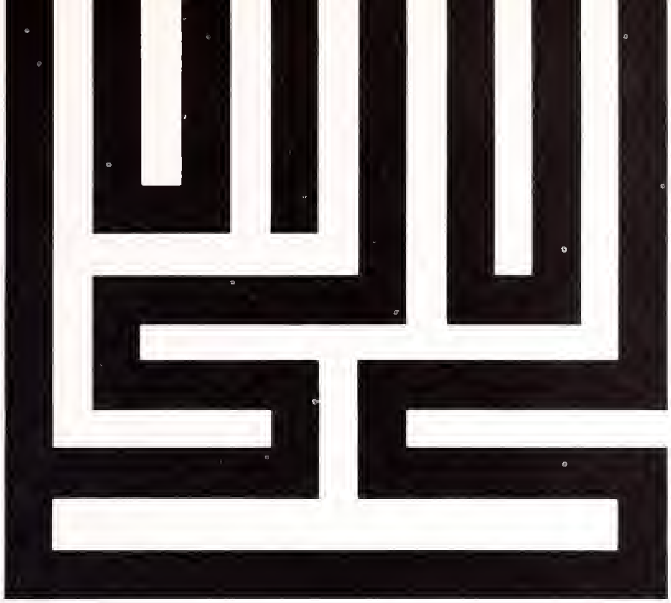
Poliomyelitis was not reported until 1910, when there were 104 cases recorded. Syphilis, gonorrhea, and chancroid made their debuts in the charts in 1919, with 5,077 cases reported, 7,910 cases and 186 cases, respectively. The first record of hepatitis was made in 1945 when there were 134 cases reported.

Steady decreases in the incidence of diphtheria, smallpox and typhoid fever have been recorded over the years. The last reported case of smallpox was recorded in 1947, the last of diphtheria in 1967. The incidence of typhoid has been under 10 since 1965.

Measles shows an up and down course, with peak years in 1926, 1932, 1935, 1938, 1943, 1946, 1948, 1950, 1954, 1956, 1958 and 1963. In 1968 and 1969, however, measles plunged to record low incidences of 353 and 401 cases.

Polio, which reached peak incidences in 1949-1955, has been recorded at less than five cases per year since 1964.

(Editor's note: There were 5,122 cases of typhoid reported in 1900.)



MSMS at work...

...WITH LEGAL OPINIONS FOR MEDICINE

MSMS seeks to legally protect and advance the medical profession through a powerful trio: the staff-manned Department of Government Relations, the physician-oriented Legal Affairs Committee, and a legal counsel.

Together they cover the broad area of evaluating and suggesting state legislation, and protecting the professional welfare of physician members.

The legal counsel and the legislative affairs manager work in concert to check through the hundreds of prospective statutes submitted each year to the Michigan legislature. Bills that need the professional expertise of legal counsel are sent to his Detroit office where he may analyze and/or write possible amendments as needed, in cooperation with MSMS staff members.

The counsel receives a large number of queries for legal advice from individual members and component societies, and from hospital administrators. After researching previous court decisions, or studying the request, he answers each letter, with a carbon that goes into the files at MSMS. Thus, an extensive law-oriented view of medical problems over the past 20 years has been collected through this MSMS service.

Counsel points out that the most prolific inquiry sources are the MSMS Legal Affairs Committee, whose meetings he attends, and the doctors and hospital administrators in the smaller communities. However, he is available to answer as many inquiries as possible from physician members and societies.

Queries cover every conceivable health topic: emergency room procedures, physician assistant problems, drug clinics, component society bylaws problems, etc.

Special article

Free enterprise the key in US to best medical care

By Robert M. Leitch, MD,
Chairman, MSMS Council

Michigan State Medical Society believes that free enterprise is the cornerstone of medical practice, that free choice in the physician-patient relationship provides for optimum medical care. MSMS also believes that "fee for service" offers the best method for equitable, economical payment for that care.

MSMS recognizes that there are some inequities and shortcomings in this system and is working to overcome them. These include:

1. Shortage of certain types of physicians, particularly in certain areas. This is a matter of distribution as well as shortage; i.e., some areas have an over-supply of certain specialists and a shortage of primary physicians. The reverse may be true in other areas.
2. Complete absence of physicians in inner-city ghettos and certain rural areas provides another problem. Solutions are being sought.
3. High costs of long-term illness, prolonged hospitalization, etc., resulting in overwhelming financial burdens for those involved.

In its attempts to overcome these shortcomings, MSMS should and does encourage the medical schools to develop more doctors and to help orient new physicians toward specialties in need. Further, we should and are trying, to develop means of encouraging new doctors to practice in true "shortage" areas.

Doctor Leitch

Health maintenance organizations may have a place in certain situations, such as inner cities and we are studying these possibilities.

In order to preserve our system of medical free enterprise, Michigan physicians must participate in frequent refresher courses and continuing postgraduate education.

Michigan physicians must be unified within one chain of organizations, i.e., county medical society, state medical society and American Medical Association. "Splintering" under a variety of allegiances is weakening and invites the "divide and conquer" technique of those who oppose us.

Michigan physicians must communicate with friends, patients, legislators and all contacts regarding our position and the reasons therefore. We also must point out the danger of any other system of medical practice.

Michigan physicians must support peer review as one method of controlling the cost of medical care while insuring that adequate care is not withheld in the guise of economy.

Michigan physicians must support some form of coverage for catastrophic costs—preferably individually purchased and government subsidized and only for the "medically indigent" with government purchasing private coverage rather than establishing a huge bureaucracy.

Michigan physicians must disavow the "health care crisis" as the propaganda of those who seek to destroy our system and replace it with socialized medicine. (Suggested reading "The Case for American Medicine" and "Hazardous to Your Health").

Michigan physicians must continue to provide the highest type of care in our power and to improve constantly.

I firmly believe that a strong, unified, enlightened, alert medical profession can provide the people of this state with optimum care at reasonable cost and can, with similar effort in other states, stem the tide of socialized medicine.

Only doctors can deliver medical care and doctors should continue to take the lead in the method of delivery. Any method other than "medical free enterprise" will result in second-rate medical care in this country. Neither doctors nor patients should allow this catastrophe to come to pass.

Highlights of Dec. 6 meeting; The MSMS Council

The MSMS Council acted on a number of important matters at the Dec. 6 meeting. Following are reports about some of the subjects:

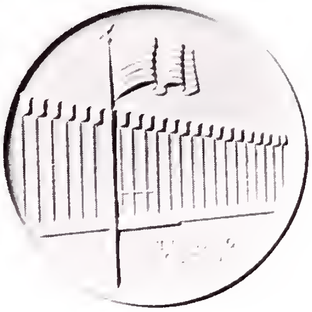
The Council heard a special presentation by Donald C. Smith, MD, of Ann Arbor, who had just been appointed as director of the new Governor's Office of Health and Medical Affairs. He noted that Governor Milliken had established the new office in an attempt to bring together in the Executive Office functions of health and medical affairs which previously had been dispersed among various state agencies and with the intent of strengthening the health planning capabilities of his office. He discussed ways MSMS could strengthen its relations with the Executive Office.

The Council referred a request from Samuel Marble, Ph.D., president of Saginaw Valley College, to the Education Liaison Committee for further study and recommendations. Doctor Marble appeared and asked for MSMS support for a proposal his college has made to the State Department of Education, the AMA, the AAMC, to begin a master's degree program in human biology. Questions were raised by councilors about how the program would differ from a possible two-year medical school.

MSMS President John J. Coury, MD, and President-Elect Brooker L. Masters, MD, reported on the recent AMA House of Delegates meeting in Cincinnati. (Excerpts from a report of the AMA meeting appear elsewhere in this issue of *Michigan Medicine.*)

An early progress report on plans for the 1973 MSMS Annual Session and several proposed changes was approved by The Council.

James D. Fryfogle, MD, chairman of the MSMS Medicaid Liaison Committee, reported the committee would meet Dec. 14 with the Governor's Liaison Committee. Council members suggested topics for the agenda.



Council reviewed a resolution from the Upper Peninsula Executive Committee re Medicaid payment mechanisms. The Council referred the UP resolution to the Medicaid Liaison Committee "with the objective of achieving a statewide, non-regional reimbursement mechanism that would permit physicians anywhere in Michigan to be paid their usual, customary and reasonable fees for services rendered."

Frank B. Bicknell, MD, chairman of the MSMS Ad Hoc Committee on Malpractice, presented a special report and suggested four recommendations that MSMS should make to the Citizens Advisory Committee. The Council concurred with the proposals "(1) that the legislation be passed that in order to have a breach of contract there must be a written guarantee, (2) that before a malpractice action is started the plaintiff must have a certificate of merit that there is true medical malpractice involved, (3) that legislation be passed to clear up presentation of evidence to return to the previous requirement that the patient must prove that the physician was negligent (as it stands now the physician must prove that he was not negligent) and (4) that legislation be passed to provide that textbooks and scientific articles cannot be used as evidence."

Council Chairman Robert M. Leitch, MD, requested Council members to send him suggestions about possible MSMS goals. This matter will be discussed further at the January Council meeting.

Michigan mediscene

Feb. 11-15—Symposium, "How does change occur in psychotherapy?" Shanty Creek Lodge, Bellaire, contact: Reuven Bar-Levav, MD, 823 Fisher Building, Detroit, 48202

Feb. 14—Infectious Disease Day, Michigan Academy of Family Physicians, Wayne County Medical Society Building, contact: Rita Feldkamp, Executive Secretary, MAFP, 933 Wing St., Plymouth, 48170

Feb. 21—Annual meeting, Michigan Society of Obstetricians-Gynecologists, Sparrow Hospital, Lansing, contact: Thomas H. Kirschbaum, MD, 178 Giltner Hall, Michigan State University, East Lansing 48823

Feb. 24—February seminar, "Human diseases of trace metal metabolism," sponsored by Michigan Society of Pathologists, Henry Ford Hospital Auditorium, contact: Jacob E. Briski, MD, Pathology Department, Saint John Hospital, 22101 Moross Road, Detroit, 48236

Feb. 26-March 2—Clinical gastroenterology postgraduate course sponsored by the American College of Physicians, Towsley Center, University of Michigan Medical Center, Ann Arbor, contact: H. M. Pollard, MD, 2012 Vinewood Blvd., Ann Arbor, 48104

Feb. 28—Council of Specialty Societies, 2 p.m., MSMS headquarters, contact: Glenn E. Moore, MD, 323 W. Second, Flint, 48503

March 11—Michigan Academy of Family Physicians, noon, MSMS headquarters, contact: Mrs. Rita Feldkamp, secretary, 933 Wing St., Plymouth, 48170

March 16-17—25th anniversary symposium, "Epilepsy '73," sponsored by Epilepsy Center of Michigan, Wayne County Medical Society headquarters, contact: Miss Cheek, Epilepsy Center of Michigan, 10 Peterboro, Detroit, 48201

March 18—Board meeting, American Association of Medical Assistants, State of Michigan Branch, MSMS headquarters, contact: Margaret Broadwell, 406 Professional Plaza, 3800 Woodward Ave., Detroit, 48201

March 20—Annual Legislative Day, Woman's Auxiliary to MSMS, Olds Plaza Hotel, Lansing, contact: Mrs. R. J. Westerhoff, 2458 Maplewood, SE, Grand Rapids, 49506

March 21—The Council, MSMS headquarters, contact: Warren Tryloff, director

March 21-22—Annual Michigan Conference on Maternal and Perinatal Health, Olds Plaza Hotel, Lansing, contact: Helen Schulte, MSMS headquarters

March 25—Spring Seminar, Michigan Branch, AAMA, East Lansing, contact: Margaret Broadwell, 406 Professional Plaza, 3800 Woodward Ave., Detroit 48201

March 28—Council of Specialty Societies, 2 p.m., MSMS headquarters, contact: Glenn E. Moore, MD, president, 323 W. Second, Flint, 48503

April 26-29—Annual state convention, AAMA, Michigan branch, Dearborn Inn, Dearborn, contact: Margaret Broadwell, 406 Professional Plaza, 3800 Woodward Ave., Detroit, 48201

May 4-5—Sixth annual cancer symposium, "Management of Advanced Breast Carcinoma," sponsored by Wayne State University School of Medicine and American Cancer Society—Michigan Division, and Michigan Cancer Foundation, Wayne County Medical Society headquarters, $25 fee, contact: Mrs. Dorothy Bewley, Symposium Registrar, 4160 John R Street, Detroit, 48201

May 9—Seminar, "Diseases of the Reticuloendothelial System," Michigan Society of Pathologists, Scott Hall, Wayne State University School of Medicine, contact: Jacob E. Briski, MD, Saint John Hospital, 22101 Moross Road, Detroit, 48236

May 10-11—Annual Gull Lake Meeting, MSMS Committee on Maternal and Perinatal Health, Kellogg Biological Station, Gull Lake, contact: Helen Schulte, MSMS headquarters

May 10-11—Sixteenth annual Clinic Days, Children's Hospital of Michigan, at Detroit Medical Center, contact: Edward W. Green, MD, Children's Hospital, 3901 Beaubien Blvd., Detroit, 48201

May 13-15—Second annual spring meeting, MSMS House of Delegates, Boyne Mountain Lodge, Boyne Falls, contact: Richard Campau, MSMS headquarters

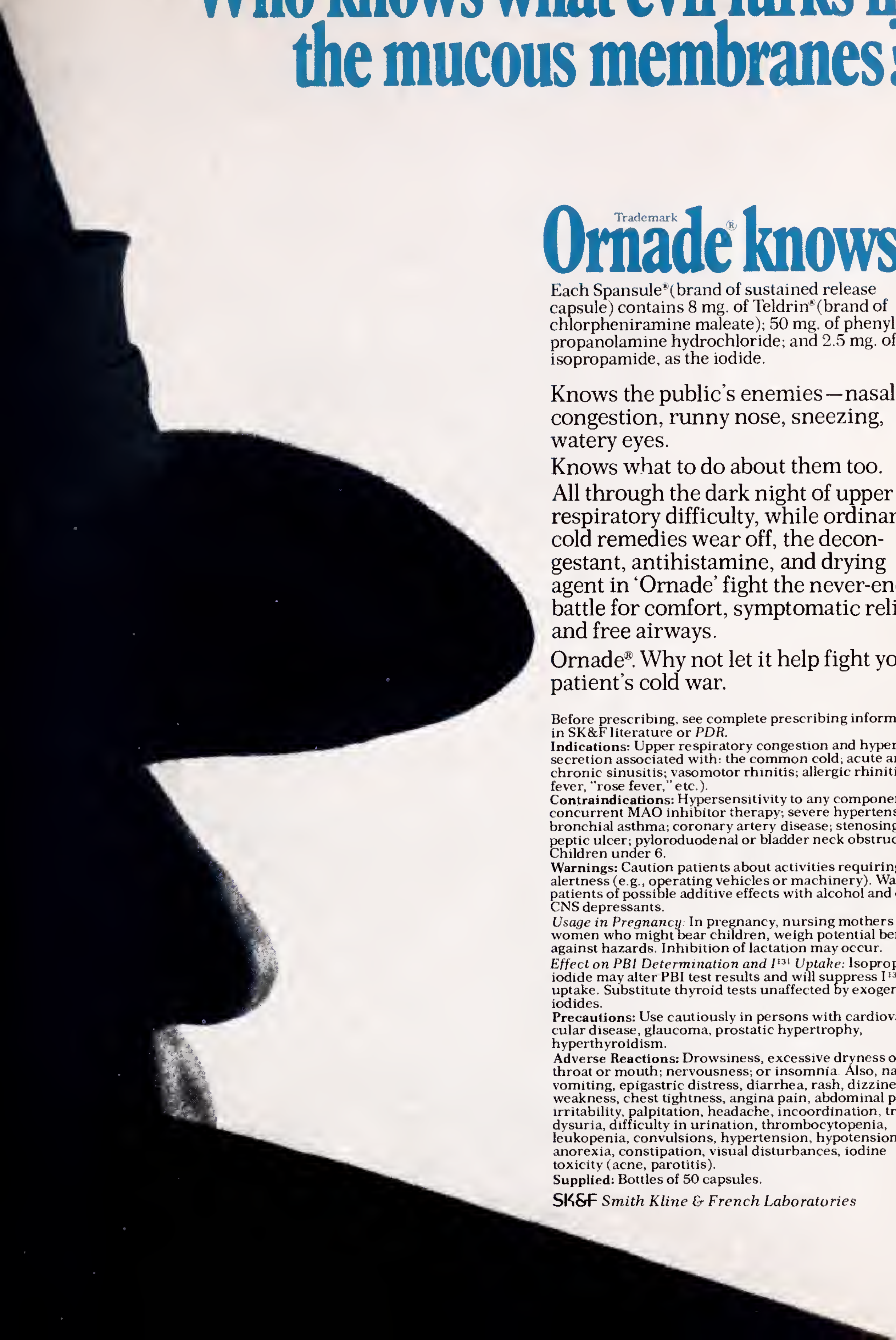
May 15-16—Spring conference, Woman's Auxiliary to MSMS, Hidden Valley Lodge, Gaylord, contact: Mrs. Fleming Barbour, 2015 Lincoln Drive, Flint, 48503

May 23—Council of Specialty Societies, 2 p.m., MSMS headquarters, contact: Glenn E. Moore, MD, president, 323 W. Second, Flint, 48503

May 24—Michigan Conference on Rural Health, Kellogg Center, East Lansing, contact: John A. Doherty, executive vice president, Michigan Health Council, 712 Abbott, East Lansing 48823

June 1-2—Annual Keyport Trauma Day, Hidden Valley Lodge, Gaylord, contact: B. E. Henig, MD, 308 Michigan Ave., Grayling, 49738

June 20—The Council, MSMS headquarters, contact: Warren Tryloff, director



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Indications: Upper respiratory congestion and hypersecretion associated with: the common cold; acute and chronic sinusitis; vasomotor rhinitis; allergic rhinitis (hay fever, "rose fever," etc.).
Contraindications: Hypersensitivity to any component; concurrent MAO inhibitor therapy; severe hypertension; bronchial asthma; coronary artery disease; stenosing peptic ulcer; pyloroduodenal or bladder neck obstruction. Children under 6.
Warnings: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Warn patients of possible additive effects with alcohol and other CNS depressants.
Usage in Pregnancy: In pregnancy, nursing mothers and women who might bear children, weigh potential benefits against hazards. Inhibition of lactation may occur.
Effect on PBI Determination and I^{131} Uptake: Isopropamide iodide may alter PBI test results and will suppress I^{131} uptake. Substitute thyroid tests unaffected by exogenous iodides.
Precautions: Use cautiously in persons with cardiovascular disease, glaucoma, prostatic hypertrophy, hyperthyroidism.
Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth; nervousness; or insomnia. Also, nausea, vomiting, epigastric distress, diarrhea, rash, dizziness, weakness, chest tightness, angina pain, abdominal pain, irritability, palpitation, headache, incoordination, tremor, dysuria, difficulty in urination, thrombocytopenia, leukopenia, convulsions, hypertension, hypotension, anorexia, constipation, visual disturbances, iodine toxicity (acne, parotitis).
Supplied: Bottles of 50 capsules.

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Clinical evidence clearly suggests that no single birth control pill can suit all women. Searle offers three pill formulations, each with a different hormone ratio and activity to cover most patients' nee

Demulen is well suited to those women for whom low-dose estrogenic activity may be preferred. Demulen has only 50 mcg. of estrogen and is moderate progestogen dominant. Intracycle bleeding, if it occurs, is most commonly seen in the first few cycles. Certain women requiring a minimal level of estrogenic activity may do well on Demulen.

for high estrogen profiles and for conservative oral contraception

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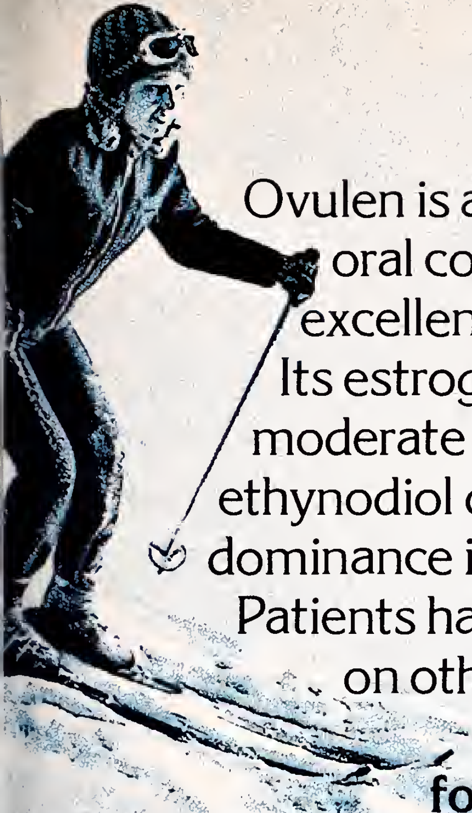
Each white tablet contains:
ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg.

Note: Oral contraceptives are complex medicati
They should be prescribed with care only
reference to the prescribing information.

For brief summary of prescribing information, please see next page.



Ovulen is a well-balanced oral contraceptive with an excellent record of patient acceptance. Its estrogen, 100 mcg. of mestranol, is relatively moderate in activity. Its 1 mg. of progestogen, ethynodiol diacetate, gives it a slight dominance in progestational activity. Patients having problems on other pills often do well on Ovulen.

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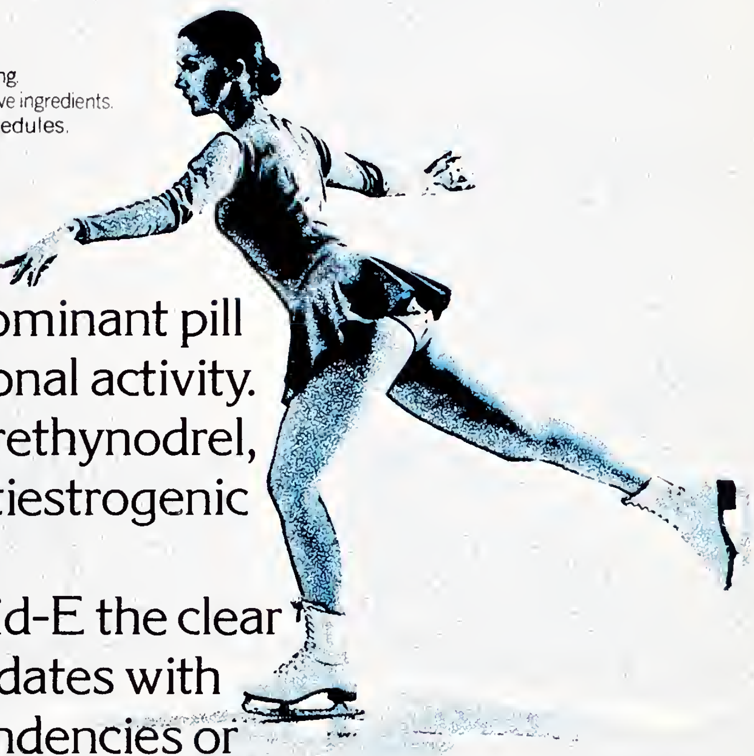
pink tablet in Ovulen-28® and Demulen-28® is a placebo, containing no active ingredients.
Both Ovulen and Demulen are available in 21- and 28-pill schedules.



Enovid-E is an estrogen-dominant pill with low progestational activity. Its unique progestogen, norethynodrel, is estrogenic and is not antiestrogenic or androgenic in activity. This probably makes Enovid-E the clear choice for those "pill" candidates with ne, hirsutism, masculine tendencies or apparent estrogen deficiency.

for excessive ovarian androgen/ low-estrogen profiles

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Each tablet contains: norethynodrel 2.5 mg./mestranol 0.1 mg.

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Each white tablet contains.
ethynodiol diacetate 1 mg./mestranol 0.1 mg.

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Each white tablet contains.
ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg.

Each pink tablet in Ovulen-28® and Demulen-28® is a placebo, containing no active ingredients.

Actions—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 1967. **2.** Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. *2*:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. *2*:651-657 (June 14) 1969. **4.** Sartwell, P. E., Masi, A. T., Arthes, F. G., Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. *90*:365-380 (Nov.) 1969.

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norethynodrel 2.5 mg./mestranol 0.1 mg.

Actions—Enovid-E acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Enovid-E depresses the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Indication—Enovid-E is indicated for oral contraception.

The *Special Note, Contraindications, Warnings, Precautions* and *Adverse Reactions* listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

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brand of norethynodrel with mestranol

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"For generations my family has insisted on Donnagel®-PG," says active young matron Mrs. T. Farnsworth Lipp (of the Upper Lipps), shown here with her charming son. "All the benefits of paregoric—without the unpleasant taste, don't you know? And Junior thinks Donnagel-PG tastes so much like bananas that I never worry about a slip between spoon and Lipp."

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With or without a silver spoon, a most tasteful solution in treating acute, non-specific
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ompanying cramping, tenesmus, and nausea as well as the diarrhea itself. Instead of
leasant-tasting paregoric, it contains the therapeutic equivalent, powdered opium,
promote the production of formed stools and lessen the urge. And it provides the
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ladonna alkaloids. And a good banana flavor to baby any taste.

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Each 30 cc. contains: Kaolin, 6.0 g.; Pectin, 142.8 mg.; Hyoscyamine sulfate, 0.1037 mg.;
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uivalent to paregoric 6 ml.) (Warning: may be habit forming); Sodium benzoate (preservative),
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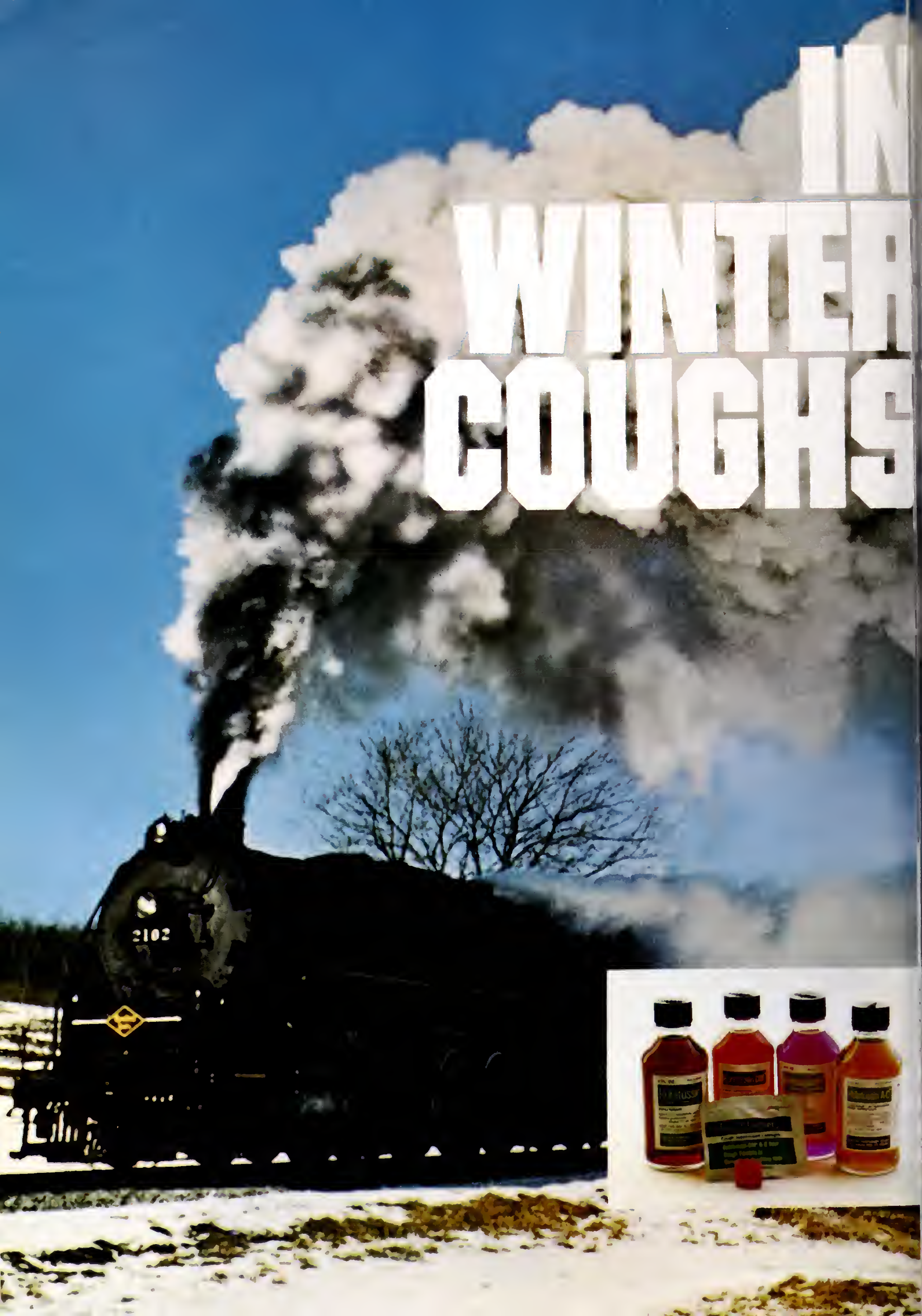
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For unproductive allergic coughs

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Each 5 cc. contains:

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Pheniramine maleate	7.5 mg.
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Non-narcotic for 6-8 hr. cough control

ROBITUSSIN-DM®

Each 5 cc. contains:

Glyceryl guaiacolate	100 mg.
Dextromethorphan hydrobromide	15 mg.
Alcohol, 1.4%	

Robitussin-DM in solid form for "coughs on the go"

COUGH CALMERS®

Each Cough Calmer contains:

Glyceryl guaiacolate	50 mg.
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Relieves cough, clears sinuses and nasal passages—keeps them "drip-dry" but not bone dry

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Select the Robitussin® "Clear-Tract" Formulation That Treats Your Patient's Individual Coughing Needs:

	Expectorant-Demulcent	Cough Suppressant	Antihistamine	Long-Acting (6-8 hours)	Nasal, Sinus Decongestant	Non-Narcotic
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ROBITUSSIN A-C®	●	●	●			
ROBITUSSIN-DM®	●	●		●		●
ROBITUSSIN-PE®	●				●	●
COUGH CALMERS®	■	■		■		■

Keep this handy chart as a guide in selecting the formula that provides the benefits you want for your patient.

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Robert M. Leitch, MD, left, chairman of the MSMS Council and leader of the MSMS Workshop for Incoming Component Society presidents, visits with Walter Rundles, MD, Genesee president-elect, and Norman Anderson, right, executive director of the Genesee County Medical Society. About 40 participated in the afternoon workshop at the MSMS Headquarters.

Richard Mellis, MD, chairman of the MSMS Committee on Maternal and Perinatal Health, asked for the support of component societies in the committee efforts re OB beds. The workshop spotlighted several of the major MSMS committees with possibilities for input by components.

Thomas C. Payne, MD, standing, describes the five 1973 projects of the MSMS Committee on Public Relations which he chairs. The program covered such topics as Medicaid, peer review, legislation, membership, SAMA-MECO and continuing medical education.

Presidents - elect of component societies visit, learn about MSMS

Some ideas for better component society programs were swapped during the workshop break by Claude A. Ludwig, MD, left, president of the St. Clair County Medical Society, Wm. T. Davidson, MD, center, also of St. Clair, and Thomas J. Setter, MD, president of the Macomb County Medical Society.

Small doses

J. H. Abronheim, MD, Jackson,
has donated more than 200 specimens collected in the 30 years he was pathologist at Foote Hospital, Jackson, to the Armed Forces Institute of Pathology in Washington, D.C. The specimens are on permanent display in the institute museum, with the notation that they are from Doctor Ahronheim and Foote Hospital.

Robert J. Baker, MD, Grand Rapids,
is new superintendent of Pine Rest Christian Hospital. Doctor Baker, who has been a psychiatrist on the Pine Rest staff since 1963, became clinical director in 1969 and also has been in charge of adolescent services.

Donald Dewitt, MD, Holland,
is one of three new vice presidents of the Interstate Postgraduate Medical Association. He will serve until the next scientific assembly of the association, which is scheduled Oct. 29—Nov. 1 in Chicago.

Kenneth R. Dorner, MD, Kalamazoo,
is new president of the Michigan Academy of Plastic Surgeons. He is a private practitioner and also is director of the plastic surgical clinic at Bronson Hospital and the cleft palate clinic at Borgess Hospital.

has been elected a full fellow of the Royal Society of Medicine. A cardiologist, Doctor Judge formerly held an affiliate membership in the society, dating from 1966 when he studied in London at the Institute of Cardiology and Guys Hospital.

Robert E. Mack, MD, Detroit,
is a new member of the Michigan Cancer Foundation board of trustees. Doctor Mack is president of Hutzel Hospital.

Bernard Meeuwsen, MD, Holland,
former Grand Rapids physician, was the recipient recently of the Outstanding Alumnus Award of Butterworth Hospital, Grand Rapids.

Harry M. Nelson, MD, Bloomfield Hills,
is a new member of the Michigan Cancer Foundation Board of Trustees. Doctor Nelson has been a leader in cancer education and services for more than 50 years, as former chief of the Hutzel Hospital gyne-

Chicago Medical Society's

MIDWEST CLINICAL CONFERENCE

and the

Illinois State Medical Society

ANNUAL MEETING

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Doctor Chapin, new Wayne County president, seeks to shape changes in medicine

A 10-point "responsive and progressive program" was outlined by Sidney Chapin, MD, in his inaugural address as the new president of the Wayne County Medical Society, Jan. 8. He succeeds Homer M. Smathers, MD.

Doctor Chapin said his program is a positive reply to the question, "Shall we be the subjects of change or shall we be the masters?"

"Together, we must examine all areas to properly equip ourselves to not only cope with change but actually to shape it for the benefit of our patients and the profession," he said.

Ned I. Chalat, MD, was announced as the president-elect to lead WCMS in 1974. A graduate of the University of Michigan, Doctor Chalat had been serving as secretary of WCMS. The new secretary is Arthur Ulmer, MD.

The 10 goals advocated by Doctor Chapin, a past president of the Michigan Heart Society and Michigan Health Council, were:

1. More equitable representation among the elected delegates and members of the Wayne County Council through hospital apportionment;
2. An up-to-date, modern, timely, newsworthy communications medium by changing the format of the Detroit Medical News;
3. A strong voice in what happens at Blue Shield and with other third-party payers;
4. A strong federation for peer review;
5. An understanding relationship with our new partner in decision-making, the consumer;
6. A strong delegation to the State Society House of Delegates that will demand the respect of the out-state caucus, and perhaps dissolve their differences;
7. Renewed relations with government health agencies and voluntary health agencies so that our expertise is not by-passed, and we can act more responsibly where the community's tax dollars and charity dollars are concerned;
8. A mechanism that defends the doctor adequately when needed;
9. Sturdy community relations so that the public really understands what health and medical care costs are all about;
10. A membership drive among the practicing physicians who are not now members of the society, a division of intern and resident membership, a special medical student membership, so that all can become active in the affairs of the society.

SMALL DOSES/Continued

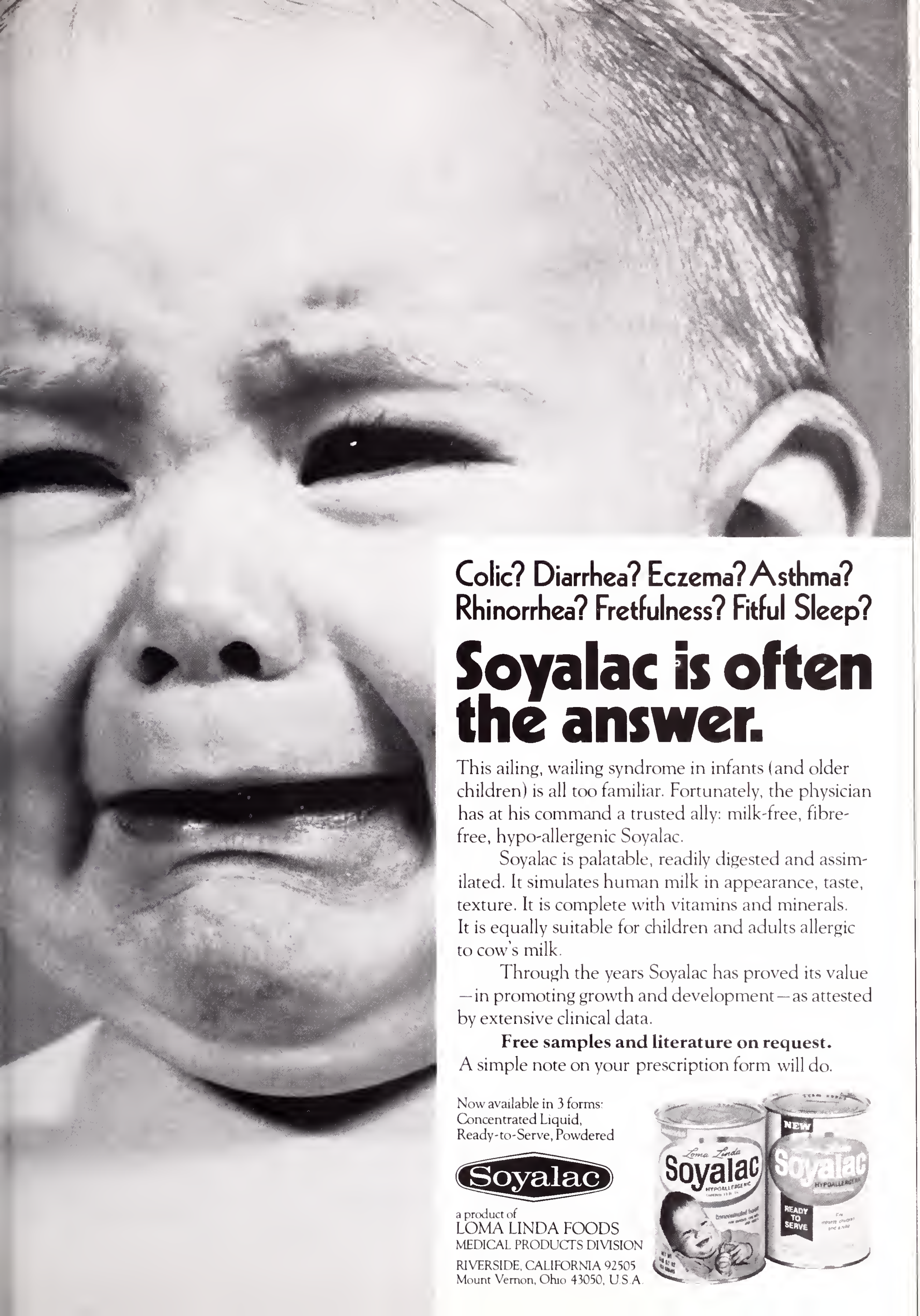
cological service and former president of the Detroit Institute of Cancer Research.

Russell J. Paalman, MD, Grand Rapids, is president-elect of the Central Association of Obstetrician-Gynecologists. He will take office as president in October, to lead a select group of 500 obstetricians-gynecologists of 28 central states.

Ralph H. Pino, MD, Farmington, one of the signers of the original Michigan Blue Shield Articles of Incorporation, was presented with a plaque marking his recent retirement from the active practice of medicine. The plaque, presented by Robert H. Hamburg, MD, chairman, Michigan Blue Shield board of directors, and John C. McCabe, Blue Shield president, honored Doctor Pino for his many contributions to Blue Shield over the years. Doctor Pino also served on Blue Shield's first board of directors.

Natalia Tanner, MD, Detroit, recently was featured in *Ebony* magazine in an article describing her work in Detroit in the area of adolescent medicine. The wife of Waldo L. Cain, MD, Detroit, she also teaches at the WSU School of Medicine.

Alexander J. Walt, MD, Detroit, is new chief of the Department of Surgery at Harper Hospital in the Detroit Medical Center. Doctor Walt also is chairman of the WSU Department of Surgery and holds national appointments. He succeeds Paul Connolly, MD, who has accepted a new administrative position as vice president and director of medical affairs in the hospital.



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Socio-economic

Family physicians still determined to end discrimination

The Michigan Academy of Family Physicians continues to consider ending "third-party payor discrimination against family physicians" as a top priority item, according to Robert L. Vitu, MD, Saginaw, academy president.

Currently, its threat of legal action against third party payors who pay family physicians differently from other doctors is just in the talking stage, says Doctor Vitu.

"We view legal action as the third and final step in our endeavors to achieve our goals," says Doctor Vitu. "But it will be taken if the first two steps don't achieve any beneficial effects."

The academy plans first to present its case for equal fees for equal service to the full Michigan Blue Shield board, and especially its consumer members, for their reactions, says Doctor Vitu.

A letter requesting such a meeting has been sent to the Blue Shield board by the MD family physicians and their DO counterparts, but no word had been received in reply as of early January, he reported.

Secondly, the family physicians plan to present their views to the public through press conferences and news releases, to see if public interest can be generated.

"We feel our stand is justified and we believe we can prove that any process other than equal fee for equal service is a discriminatory practice as far as our patients are concerned.

"We feel our patients in effect are subsidizing the patients of other physicians who are paid a higher fee than we for providing the same service. Our patients pay the same Blue Shield premiums."

The MAFP in 1971 adopted a resolution to obtain "identical fee for identical service." At its annual convention in 1972, the MAFP board was authorized to use legal action if necessary to prevent third party payor discrimination against family physicians.

A $25 assessment of all MAFP members was then authorized to pay for such legal action, but it has not been collected yet, Doctor Vitu says.

Progress report on Washtenaw HMO

As of the first of January, the prepaid health care-health maintenance organization program proposed for Washtenaw county families was rounding out its staff and further developing its organization.

Plans are for the program, first announced in October at the annual reunion of the University of Michigan Medical Center Alumni Association, to be operative in a year.

Purposes of the program are to design a prepaid medical care, health maintenance organization-type system to serve 7,000 families in the county in addition to Blue Cross-Blue Shield plans, to train primary care physicians within the system, and to do research on the effectiveness of this delivery system.

The Washtenaw facility probably will be located on the U-M Medical Center campus. It will provide in- and out-patient care and will include university employees and faculty. Families enrolled would pay a yearly fee and would receive whatever normal care they need in or out of the hospital.

MSU experts analyze UP health care industry

A new analysis has led economic experts at Michigan State University to declare that increased public funding and strong local leadership are needed if Michigan's rural health care industry is to survive.

In a study entitled "Health Care Industries in the Michigan Grand Traverse and Copper Country Regions: Case Studies in Community Resource Development," the

MSU EXPERTS/Continued

MSU experts found variances which point out what is necessary for successful health care to be maintained in Michigan's rural areas.

In the Grand Traverse area, they report, health services are now independent. They provide as much as 10 percent of the area's income, and are actually a thriving export industry.

In contrast, the Copper Country must have outside support to survive, reports the team from the MSU Department of Agricultural Economics.

In both areas, local and state support is significant, the report says. But effective local leadership has helped produce the thriving medical industry in the Grand Traverse area.

On the other hand, medical needs in the Copper Country have increased at a greater rate than facilities. Already as much as 37 percent of the Copper Country's total public revenue goes to health and welfare assistance and local leaders in the area must now seek more public aid, say the MSU experts.

AMA appoints six state doctors

Six Michigan physicians have been appointed to AMA Councils and Committees. The doctors, whose names are announced by Donald N. Sweeny, Jr., MD, Michigan AMA delegation chairman, are,

Herbert A. Raskin, MD, Southfield, chairman, Committee on Alcoholism and Drug Dependence;

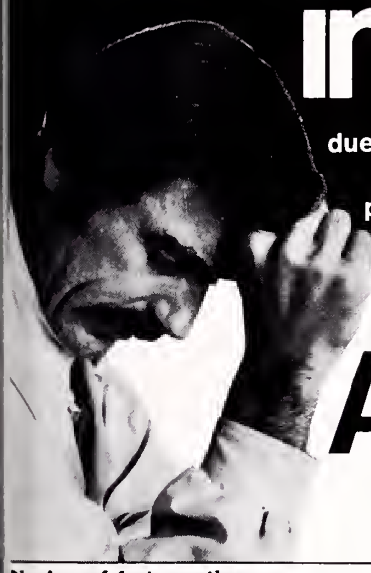
Everett R. Harrell, Jr., MD, Ann Arbor, member, Committee on Cutaneous Health and Cosmetics;

William W. Jack, MD, Grand Rapids, member, Committee on Maternal and Child Care;

Robert E. Rice, MD, Greenville, member, Council on Rural Health;

Maurice H. Seevers, MD, Ann Arbor, member, Committee on Alcoholism and Drug Dependence, and

Donald N. Sweeny, Jr., MD, Detroit, member, AMA Disability Insurance Claims Review Committee.



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The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

NEW CLINICAL STUDY

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T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the American Fertility Society

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Double-Blind Study and Type of Patient: 100 patients suffering from impotence. Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% on placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

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Each yellow tablet contains:
Methyl Testosterone ..2.5 mg.
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Dose: 1 tablet 3 times daily.
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Thiamine HCL ....10 mg.
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Thiamine HCL ....25 mg.
Glutamic Acid ....100 mg.
Pyridoxine HCL ....5 mg.
Niacinamide ....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 ....2.5 mcg.
Riboflavin ....5 mg.
Dose: 2 tablets daily.
Available: Bottles of 60, 500.

Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiorenal disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males

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Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema

Hypercalcemia may occur, particularly in immobilized patients: use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References: 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12·69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltestosterone-thyroid compound. West Med 5·67, 1964 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone J Clin Endocr 19·936, 1959 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79·863, 1958. 6. **Osol, A., and Farrer, G. E.** United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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Michigan delegation proposing new section on emergency medicine

The AMA House of Delegates at its June meeting in New York City will receive a report from the AMA Board of Trustees about the establishment of a proposed Section on Emergency Medicine.

The proposal for the new section, advocated in a resolution sponsored by the Michigan State Medical Society delegation, was well-received by the AMA delegates at the winter meeting in Cincinnati.

At that meeting, Reference Committee H which studied the Michigan resolution reported that the reference committee "was convinced that emergency medicine is rapidly becoming a recognized medical service, that physicians who practice emergency medicine render a valuable service, and that the number of physicians in this area is rapidly increasing."

The reference committee further stated it believes "that establishment of a Section on Emergency Medicine by the AMA will provide educational assistance for physicians in this field and will aid in the training of allied health professionals." The reference committee endorsed the intent of the resolution and urged the house to send along the Michigan resolution to the AMA Board of Trustees, with instructions to report back in June.

The American College of Emergency Physicians, the new professional association in the area of emergency medicine, was started in Michigan by John Weigenstein, MD, of Lansing. MSMS provided early advice and support, ACEP rented space at the MSMS headquarters and contracted for executive staff assistance until ACEP had grown large enough for its own professional staff and headquarters. ACEP has continued its national headquarters in East Lansing, one block from MSMS.

The Michigan resolution was introduced by Joseph Witter, MD, Rochester. Paul T. Lahti, MD, Royal Oak, an MSMS delegate, was a member of Reference Committee H. Doctor Witter, who is a member of ACEP, was not a candidate for re-election at the fall MSMS House of Delegates meeting and thus he completed his term at the Cincinnati meeting.

Michigan med students taking their electives at neighbor schools

Growing numbers of medical students are taking advantage of the new arrangement that allows them to study in any of the state's three medical schools and receive credit at their home school.

Currently, according to Charles Votaw, MD, U-M assistant dean for medical school curriculum, four U-M seniors are taking electives at Wayne State University School of Medicine, one WSU senior is studying internal medicine at the U-M, and two MSU seniors are studying at the University of Michigan, one in hematology oncology and one in the Irving Feller Burn Unit.

Three of the U-M students at Wayne State University are doing night emergency work at Wayne County General Hospital and the fourth is studying under the WSU general practitioner preceptor program.

The program went into effect July 1, 1971 following approval in the spring of 1971 by the schools of medicine at Wayne, Michigan and Michigan State, including the MSU School of Osteopathic Medicine.

"At first, we had some difficulty interesting students," reports Doctor Votaw. "Then, the first two students to participate reported back with good experiences and we now are getting increasing interest."

Doctor Votaw explains that he has no difficulty in placing students who wish to participate in the program. "We have more openings than students to fill them," he says.

Up to a given deadline, each school's own students have first choice of elective offerings. Whatever positions are still open after the deadline are filled on a first come-first serve basis by students from the other schools.

Exchange students are indistinguishable from a school's regular students in class, Doctor Votaw continues. They pay tuition at their own schools and are evaluated in whatever manner is characteristic to their home schools.

"I personally feel this program is very worthwhile and exciting," says Doctor Votaw. "From everything I hear I expect many more requests for exchanges from next year's classes."

Advertisement

> *"The history of science, and in particular the history of medicine . . . is . . . the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."*
>
> *—George Sarton, from "The History of Medicine Versus the History of Art"*

Are combination drug products useful in treatment involving concomitant use of two or more drugs?

Opinion

Results of a questionnaire to 7,000 physicians:

62.9%
Believe combination drug products are useful.

13.8%
Do not believe combination drug products are useful.

Are combination drug products useful in treatment involving concomitant use of two or more drugs?

Opinion & Dialogue

Doctor of Medicine

Louis Lasagna, M.D.
Professor and Chairman
Department of
Pharmacology & Toxicology
University of Rochester
School of Medicine
and Dentistry

Obviously, many drugs are given concomitantly. Whether it makes sense to combine medications in one preparation, be it capsule, tablet, or liquid, is a question that can be answered only by examining the advantages and disadvantages in the individual case.

Among the advantages is, first of all, convenience. The more medications that are taken concurrently and the more complicated the directions, the less likely the patient is to take medications accurately. From the standpoint of convenience and accuracy, and economy as well, you can make an important case for putting medications together in one preparation, as long as they are compatible.

By the same token, when you prescribe a properly tested and rational combination, you should have less worry about pharmaceutical or pharmacological compatibility – and about reasonable dosage ratios as well. Compatibility of the formulation should be demonstrated in the laboratory and clinic before the product is available for prescription–which is more than can usually be said for the physician's own spontaneous creations. And, the dosage ratios employed in rational precompounded combinations are designed to meet the needs of substantial numbers of "typical" patients.

There is no doubt that many "atypical" patients are to be found, and for them the prefabricated combination must be rejected. But that hardly argues for eliminating rational combinations from the market. Think, for example, of the problems that would arise if the components of widely accepted combinations, like the oral contraceptives and the diuretic-antihypertensives, always had to be prescribed, purchased and ingested separately.

One disadvantage that comes to mind is some doctors' unawareness of the ingredients a given combination contains. For example, a doctor might know that a patient is allergic to aspirin but forget that a certain analgesic mixture, which he knows only by its trade name, contains aspirin. His prescription, then, causes considerable discomfort, to say the least. This problem is a function of physician education, rather than of combination therapy as such. Improving doctors' knowledge about all medicaments they prescribe is a problem that deserves tackling on its own.

Another accusation leveled at combination drugs is that they encourage sloppiness of diagnosis and treatment. In many cases, however, a combination may prove to be the most effective choice. A good example of the usefulness of combinations appears in a recent article in the *Journal of Chronic Diseases* on the efficacy and side effects of an antihypertensive containing three ingredients, in which the track records of the combination drug and the individual ingredients were compared. Interestingly enough, whether the drugs were given individually or together, incidence and severity of side effects were the same. But blood pressure control was invariably better when the drugs were taken in one combination tablet than when they were taken separately (in "titratable" dosage) or in two or three different tablets.

Deciding which combinations constitute rational therapy obviously leads to a discussion of who is to determine which should be used and which should not. Realistically, I think combinations should be evaluated somewhat differently if they are old and established or new and untried.

In today's regulatory atmosphere, there is no possibility of a new combination being put on the market without a substantial amount of acceptable evidence in the form of controlled trials that show it to be safe and efficacious. On the other hand, I believe a different set of standards should apply to combination preparations that have been around for a long time. In other words, physician acceptance over a long period should be given some weight as evidence of the efficacy and safety of these drugs.

The FDA, however, does not seem to share this attitude. It often requires, for these older products, controlled trials that will monopolize the time of already overtired investigators and cost a greal
of money. I wish we c
agree on a "grandfa
clause" approach to pr
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that have an appare
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One of a series

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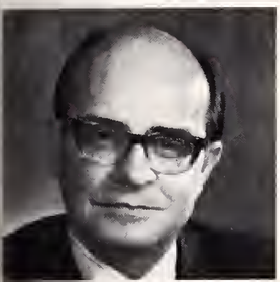

If two medications are ised effectively to treat a ertain condition, and it is nown that they are com-)atible, it clearly is useful ınd convenient to provide hem in one dosage form. t would make no sense, in act it would be pedantic, o insist they always be)rescribed separately. To void the appearance of)edantry, the "expert" de- ries the combination be- ause it is a fixed dosage orm. When the "expert" nvokes the concept of fixed osage form he obscures he fact that single-ingre- ient pharmaceutical prep- rations are also fixed osage forms. By a singular emantic exercise he im- lies a pejorative meaning) the term "fixed dose" nly when he uses it with espect to combinations. Vhat is ignored is the sim- le fact that only in the arest of circumstances oes any physician attempt) titrate an exact thera- eutic response in his pa- ent. It is quite possible ıat some aches and pains ill respond to 500 mg. of spirin yet that fact does ot militate against the *us- al* dose being 650 mg.

The other semantic ploy ten called into play is to escribe a combination roduct as rational or irra- onal.

Take antibiotic mixtures, ıe source of much of the iticism generated against combinations generally. Obviously, no one should be exposed willy-nilly to the potential side effects of two or three antibiotics when only one is needed. At the same time there are cases where it is prudent to prescribe more than one. The clinician is the judge in these circumstances, as he should be.

There is no clear definition of the word rational. Most persons, I suppose, would find it synonymous with reasonable, but in many circumstances it may best be defined as the opinion of those in power at the moment.

Other factors govern combination therapy, not the least of which has been its broad use by practicing physicians anxious to achieve convenience in prescribing, to reduce medication error, and to save money for their patients. Combinations clearly have met the test on all three counts.

I have been impressed by studies showing that the rate of error climbs markedly with the number of medications to be taken, even with sophisticated patients. When medically justified, therefore, this factor alone supports the logic of combination therapy.

The cost argument for combinations appears to be irrefutable. In 1971, R. A. Gosselin studied the 71 combination products (excluding oral contraceptives) among the 200 most prescribed drugs. The study found that if all 71 products were discontinued, and if each ingredient in these combinations were prescribed separately, the price of medicines to patients would jump by $443.2 million on a national basis! At a time when the cost of medical care is under so much fire, it would be nonsensical to boost costs without clearly irrefutable medical reasons.

The part played by government on this question, of course, is fundamental. The FDA should play a role in determining which combinations are reasonable. That role, as defined by law and regulation, is to ensure that any medication on the market is safe and effective in line with its label claims. Certainly combinations are entitled to as much consideration as single entities—neither more nor less. So long as the addition of one drug to another does not make either less safe, or less effective, so long as they are compatible in a formulation, we have a reasonable product. It makes no sense to recommend the use of two products for certain conditions and to deny their being combined in a single form. An unhappy side effect of the problem concerns the efficacy panel discussions of many products submitted for review. The term "effective, but" has been freely interpreted to mean "ineffective" in toto, regardless of the merit of the individual drugs. This interpretation has placed numerous useful combination products in needless jeopardy.

In reading the actual reports of the review panels, it seems clear that some of the ratings were based less on scientific research and clinical observation than on the "informed" opinions of the panelists. These "informed" opinions were accepted at face value, while the "informed" opinions of others who had used the products were rejected. All of this put combination products into a sort of scientific never-never land.

It should be kept in mind by all, government as well as others involved in our health care system, that advances in therapy are seldom made in leaps and bounds but rather by small painstaking steps—and that some of these steps have resulted from research in combination drugs as well as with single entities. Given the near-infinite biologic variation in patient response, this is hardly surprising to clinicians. It should not be to regulatory agencies either.

In the end, the practicing physician is in the best position to decide if a particular combination makes sense. Such a decision should not be made exclusively by those whose responsibility for continuing clinical care is limited. Clinicians are the best judges of efficacy because the ultimate proof of any product's effectiveness is acceptance by physicians who have observed its actions in patients over time. The corollary statement may be made about over-the-counter medicines, which would not long survive if they failed to afford the relief the user anticipates. That the antihistamine in a "cold" remedy may not *always* be necessary is no reason to proscribe the combination generally.

Opinion & Dialogue

What is your opinion, doctor?
We would welcome your comments.

P·M·A

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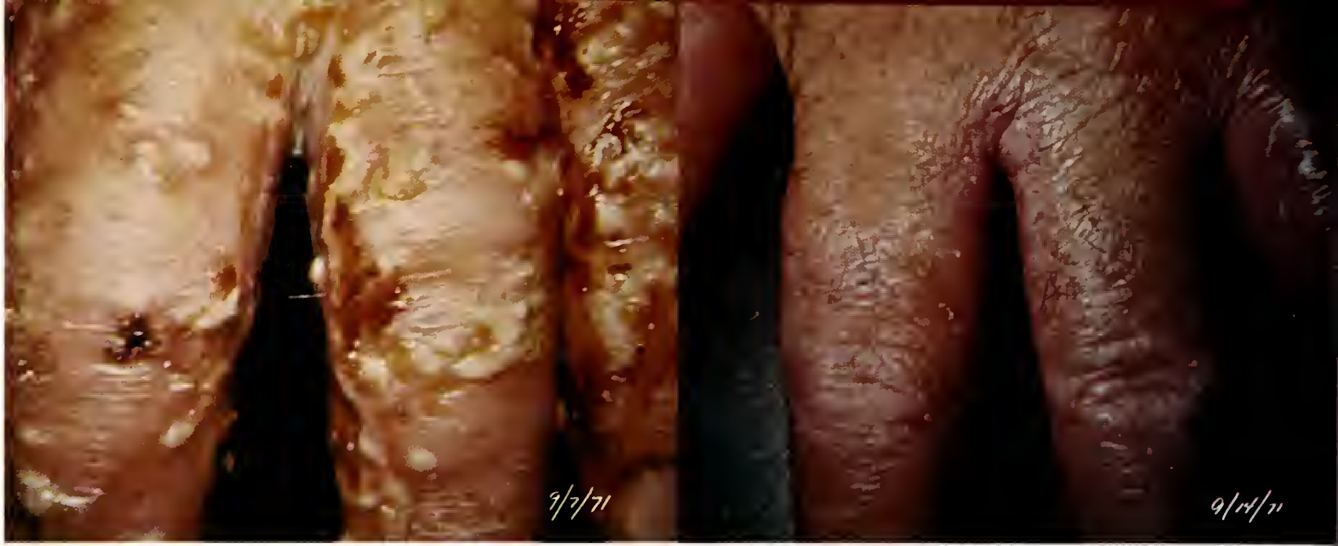

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Clinical Data:

Patient: 47-year-old male.
Diagnosis: Severe pyoderma, left hand.
Culture: *Staphylococcus aureus, coagulase* positive and sensitive to MINOCIN.
Temperature: 102° F
Therapy: MINOCIN Minocycline HCl Capsules, 100 mg: 200 mg *stat,* 100 mg every 12 hours. Medication began 9/7/71. By fourth day, temperature was normal and pustular lesions considerably improved. Last dose taken 9/14/71.
Concomitant therapy: None.†

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Indications: For the treatment of susceptible infections; e.g., *E. coli, D. pneumoniae.* For full list of approved indications consult labeling.
Contraindications: Hypersensitivity to any tetracycline.
Warnings: The use of tetracyclines during tooth development (last half of pregnancy, infancy and childhood to the age of 8 years) may cause permanent discoloration of the teeth (yellow-gray-brown). This is more common during long-term use but has been observed following repeated short-term courses. Enamel hypoplasia has also been reported. Tetracyclines, therefore, should not be used in this age group unless other drugs are not likely to be effective or are contraindicated. In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, use lower total doses, and, in prolonged therapy, determine serum levels. Photosensitivity manifested by an exaggerated sunburn reaction has also been observed in some individuals taking tetracyclines. Advise patients apt to be exposed to direct sunlight or ultraviolet light that such reaction can occur, and discontinue treatment at first evidence of skin erythema. Studies to date indicate that photosensitivity does not occur with MINOCIN Minocycline HCl. In patients with significantly impaired renal function, the antianabolic action of tetracycline may cause an increase in BUN, leading to azotemia, hyperphosphatemia, and acidosis. CNS side effects (lightheadedness, dizziness, vertigo) have been reported, may disappear during therapy, and always disappear rapidly when drug is discontinued. Caution patients who experience these symptoms about driving vehicles or using hazardous machinery while taking this drug. *Pregnancy:* In animal studies, tetracyclines cross the placenta, are found in fetal tissues, and can have toxic effects on the developing fetus (often related to retardation of skeletal development). Embryotoxicity has been noted in animals treated early in pregnancy. Safety of use during human pregnancy has not been established. *Newborns, infants and children:* All tetracyclines form a stable calcium complex in any bone-forming tissue. Prematures, given oral doses of 25 mg./kg. every 6 hours, demonstrated a decrease in fibula growth rate, reversible when drug was discontinued. Tetracyclines are present in the milk of lactating women who are taking a drug of this class.

Precautions: Use may result in overgrowth of nonsusceptible organisms, including fungi. If superinfection occurs, institute appropriate therapy. In venereal diseases when coexistent syphilis is suspected, darkfield examination should be done before treatment is started and blood serology repeated monthly for at least four months. Because tetracyclines have been shown to depress plasma prothrombin activity, patients on anticoagulant therapy may require downward adjustment of such dosage. Test for organ system dysfunction (*e.g.,* renal, hepatic and hemopoietic) in long-term use. Treat all Group A beta hemolytic streptococcal infections for at least 10 days. Avoid giving tetracycline in conjunction with penicillin.

Adverse Reaction: GI: (with both oral and parenteral use): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in anogenital region. *Skin:* maculopapular and erythematous rashes. Exfoliative dermatitis (uncommon). Photosensitivity is discussed above ("Warnings"). *Renal toxicity:* rise in BUN, dose-related (see "Warnings"). *Hypersensitivity reactions:* urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus. In young infants, bulging fontanels have been reported following full therapeutic dosage, disappearing rapidly when drug was discontinued. *Blood:* hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia. *CNS:* (see "Warnings.") When given in high doses, tetracyclines may produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

NOTE: Concomitant therapy: Antacids containing aluminum, calcium, or magnesium impair absorption; do not give to patients taking oral minocycline. Studies to date indicate that absorption of MINOCIN is not notably influenced by foods and dairy products.

***Indicated in infections due to susceptible organisms. Culture and sensitivity testing recommended. Tetracyclines are not the drugs of choice in the treatment of any staphylococcal infection.**

†Case Report, Clinical Investigation Department, Lederle Laboratories.

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Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

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Doctor,

What do you know about venereal disease?

Here's a quiz to help you find out

How well informed are practicing physicians on the diagnosis and treatment of venereal disease? Are they, in general, aware that gonorrhea is the most prevalent communicable disease, both in Michigan and across the nation, and that its incidence is great enough to put it in the epidemic stage?

Because of doubts as to the attention given gonorrhea and syphilis by many physicians, the MSMS Committee on Public and Environmental Health, chaired by Louis R. Zako, MD, of Westland, has been conducting a special educational effort over the last year. The committee has been cooperating closely with the Michigan Department of Public Health, which is now offering a special diagnostic service in the 16 counties with the highest incidence of gonorrhea. Diagnosis and treatment of gonorrhea in women who suffer from the disease but have no symptoms is the special target in this federally-funded program.

Physician education appears to be needed as the key to success in the attack on venereal disease, according to Doctor Zako. And his views were verified in a study conducted under the direction of the National Commission on Venereal Disease, which was established in 1971 by the U.S. Department of Health, Education and Welfare.

Doubting the adequacy of either professional or public education, the commission arranged for an evaluation of the former through a test given to 387 physicians entering the army and attending orientation sessions at the Army Medical Field Service School, Brooke Army Medical Center, Fort Sam Houston, Texas.

The quiz was given to three classes of new medical officers in July and August, 1971, and the results in the three classes were virtually the same. They had an overall failure rate of 72 percent, using a score of 70 as a passing grade on a scale of 100.

"Even using 60 as a passing grade leaves 21 percent of these relatively recent medical school graduates in the failing zone," reported Col. Jerome H. Greenberg, MD, director of health and environment for the U.S. Surgeon General's office, in the June 26, 1972, issue of the *Journal of the American Medical Association.* "At best, this representative group of young physicians can be said to have a marginal knowledge of venereal disease."

Col. Greenberg also expressed doubts that any change has taken place since 1966 when a study of medical schools determined that the average time that venereology was taught as a separate subject was 8.2 hours and, in combination with other subjects, 11.2 hours.

Col. Greenberg has supplied *Michigan Medicine* with a copy of the Army VD Quiz, noting that it was developed as a guide for army training and might not in all its aspects be significant from the civilian standpoint.

The quiz follows, with answer blanks for readers who wish to evaluate their knowledge in the area. The answers supplied by the army and a table for scoring appear on Page 189.

Venereal Disease, Diagnosis, Treatment and Control

(This test was written for statistical purposes only and was designed to determine the scope and adequacy of venereal disease training the new medical officers had received prior to entering military service.)

Multiple Choice

1. With a low titred VDRL test, a patient with no clinical evidence of syphilis may:

( ) A. Have syphilis and was never treated or was inadequately treated.
( ) B. Have had syphilis and was successfully treated at some time in the past.
( ) C. Have a biologic false positive test.
( ) D. All of the above.

2. The term treponemal serologic test refers to the fact that the antigen used in the testing is either a treponeme or a product derived therefrom. One of the following, however, utilizes living organisms in the actual test. Which one:

( ) A. FTA
( ) B. TPI
( ) C. RPCF
( ) D. Kolmer

3. In determining whether or not CNS syphilis is active, the most important spinal fluid finding is:

( ) A. Reactivitiy of the VDRL test
( ) B. Protein
( ) C. Cells
( ) D. Colloidal gold curve

4. To cover all possibly infected contacts, patients with secondary syphilis should be interviewed for sexual contacts of the past:

( ) A. One month
( ) B. Three months
( ) C. Six months
( ) D. Twelve months

5. About one-fourth the patients with a primary syphilis lesion will have a non-reactive serologic test for syphilis. Therefore, the only *absolute* method of diagnosis is:

( ) A. History of sexual contact
( ) B. Clinical characteristic of the lesion
( ) C. The darkfield examination
( ) D. Establish diagnosis of syphilis in a sexual contact

6. Infectious mononucleosis and syphilis may have all of the following signs or symptoms in common except:

( ) A. Positive heterophil antibody test
( ) B. Reactive serologic test for syphilis
( ) C. Low grade fever and generalized rash
( ) D. Generalized lymphadenopathy

7. A woman in her third month of gestation is found to have a reactive VDRL 1:1. A search of her medical history revealed that she had Bicillin four years previously for diagnosis of latent syphilis. At that time VDRL was 1:8. At follow-up examination one year later the titre was 1:1 and all physical findings negative. The physician managing this patient should:

( ) A. Treat immediately to avoid congenital syphilis
( ) B. Do a spinal tap
( ) C. Document the adequacy of past treatment and follow carefully
( ) D. Ask for a FTA-ABS

8. The most important reason for the difficulty in gonorrhea control is:

( ) A. At present no epidemiology is being applied
( ) B. The N. gonorrhea is becoming resistant to penicillin
( ) C. In females the disease by and large is asymptomatic
( ) D. Diagnostic tests in the female are limited

9. The most accurate and practical diagnostic test for gonococcal urethritis in the male is:

( ) A. Gram stain of urethral exudate
( ) B. Culture using Thayer-Martin medium
( ) C. Culture using conventional GC base media
( ) D. Fluorescent antibody

10. The primary lesion in lymphogranuloma venereum is an evanescent:

( ) A. Inguinal adenitis
( ) B. Papule or vesicle
( ) C. Ulcer
( ) D. None of these

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In fact, there are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

NDICATIONS: Based on a review of this drug by the National cademy of Sciences–National Research Council and/or other nformation, the FDA has classified the indications as follows:

ossibly Effective:

. For the relief of symptoms associated with cerebral vascular insufficiency.

. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's disease) and Raynaud's disease.

. Threatened abortion.

inal classification of the less-than-effective indications requires further nvestigation.

MPOSITION: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

DOSAGE AND ADMINISTRATION: 10 to 20 mg. three or four times daily.

CONTRAINDICATIONS AND CAUTIONS: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

ADVERSE REACTIONS: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

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11. The incubation period for symptoms of acute chancroid infection in the male is:

( ) A. 3-5 days
( ) B. 2-14 days
( ) C. 7-21 days
( ) D. 10-90 days

True/False

12. Darkfield examinations of the rectum and anus are not necessary and difficult because of other treponemes present in the rectum.

( ) A. True
( ) B. False

13. *Epidemiologic treatment* refers to the treatment of *bona fide* sexual contacts to infectious syphilis who may or may not be in the prodromal or incubating stages of disease.

( ) A. True
( ) B. False

14. Gonorrheal infections have been shown to be asymptomatic in 10-15 percent of male cases.

( ) A. True
( ) B. False

15. Initial treatment of acute gonorrhea in the female who is not sensitive to penicillin is 4:8 million units of benzathine penicillin.

( ) A. True
( ) B. False

16. Syphilis is communicable during the second stage.

( ) A. True
( ) B. False

17. Congenital syphilis results from prenatal transmission of spirochetes from mother to fetus in the first three months of pregnancy.

( ) A. True
( ) B. False

18. Chancroid is a self-limited infection.

( ) A. True
( ) B. False

19. The treatment of choice for chancroid is sulfasoxizole.

( ) A. True
( ) B. False

20. In male gonorrhea any urethral discharge three days after appropriate initial treatment means the patient should be retreated with the same regimen.

( ) A. True
( ) B. False

Match the Appropriate Number. An Item May Be Used More Than Once.

A. Syphilis
B. Gonorrhea
C. Chancroid
D. Lymphogranuloma venereum
E. Granuloma inguinale

21. ( ) Ulcer with clean base and indurated edges

22. ( ) Penile ulcer with ragged edges, dirty gray base

23. ( ) Large, friable ulcerated areas with beefy red base

24. ( ) Purulent urethral discharge

25. ( ) Rectal stricture

26. ( ) Purulent arthritis

27. ( ) Frei test

28. ( ) Penicillin and Probenecid

29. ( ) Multiple sinus tracts

Here are answers to VD quiz

Key for grading your performance on the venereal disease quiz: Correct answers: 1, D; 2, B; 3, C; 4, C; 5, C; 6,A; 7, C; 8, C; 9, A; 10, B; 11, A; 12, B; 13, A; 14, A; 15, B; 16, A; 17, B; 18, B; 19, A; 20, B; 21, A; 22, C; 23, E; 24, B; 25, D; 26, B; 27, D; 28, B, and 29, D.

Scoring

Percentage of Correct Answers	Number of Officers	Number of Correct Answers (29 Questions)
90-100	0	27-29
80-89	16	24-26
70-79	93	21-23
60-69	196	18-20
50-59	65	15-17
40-49	14	12-14
30-39	2	9-11
20-29	1	8 or less

Sign your names clearly, Doctors, pharmacists ask

The physician members of the MSMS Liaison Committee with the Michigan State Pharmaceutical Association suggest that residents and interns practicing in institutions make an effort to write their signatures on prescription blanks as clearly as possible, and if necessary, to print their names next to their signatures for easy legibility.

The recommendation is made following the arrival of a letter at MSMS headquarters from Louis M. Sesti, RPh, executive director, Michigan Pharmaceutical Association.

Mr. Sesti explained in the letter that "the pharmacist can encounter significant difficulties when attempting to contact the prescriber for consultation," and that for other reasons, "difficulties in deciphering the signatures of prescribers on medical institutional prescription blanks. . . is not a healthy situation."

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VERY BUSY PRACTICE FOR SALE due to recent death of only physician in community. Office will accommodate two physicians to serve trading area. Up to date new equipment. Office carpeted, air conditioned. Three examining rooms, one OB room, one X-Ray room, therapy room, developing room for X-Ray. Partial basement, large work room, business office, two bathrooms, waiting room, two furnaces, incinerator, about 1½ blocks from lake. Area has golf, skiing, good schools and churches. FM throughout building, minor surgery room with overhead light and electric examining table, EKG machine. Contact: Mrs. Dean Seger, 107 W. Lake Street, Lake City, Michigan 49651. Phone: Office 616—839-4359, home 616—839-4554.

FOR RENT: Professional Office building to be built in Petoskey, Michigan. Will be ready for occupancy by Labor Day, 1973. Large parking lot across the street. Offices from 1000 to 4000 square feet. Petoskey is the medical center of the North and year round vacationland, with skiing, golf, fishing, etc. Contact: Thomas Turcott, OD, 312 Mitchell St., Petoskey, Michigan 49770. Phone (616) 347-6151 or 347-2688.

THE HURON COUNTY Social Services Board is interested in hearing from any physician interested in assuming the Medical Directorship of the Huron County Medical Care Facility located in Bad Axe, Michigan. This facility is an 89 bed institution and would be ideal for the doctor that wants to reduce his practice but not retire completely or for the new doctor who needs some immediate security while building up a practice. If you are interested in geriatrics, feel that 10 to 12 hours a week of your time in an extended care facility would not handicap your future plans, please contact us and you will be sent a job description and other details. Huron County Social Services Board, Huron County Bldg., #102, Bad Axe, Michigan 48413.

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In memoriam

Russell F. Fenton, MD
Birmingham

Russell Franklin Fenton, MD, long-time Detroit-area physician, died Jan. 6 at the age of 74. Doctor Fenton was a general practitioner.

He was a staff member at Mt. Carmel Mercy and Grace Hospitals, where he was chairman of the general practice section, and he was chief of staff at Brent General Hospital.

Doctor Fenton was past president of the MSMS general practice section and had served as a Wayne County delegate to the MSMS House of Delegates. He also was a past president of the Michigan Academy of General Practice and former delegate to the American Academy. He was a graduate of the University of Michigan Medical School.

Bert F. Howell, MD
Grosse Pointe Farms

Bert Frank Howell, MD, Detroit physician and surgeon for 36 years, died Dec. 7 at the age of 66.

Doctor Howell was affiliated with Holy Cross and East Side General hospitals in Detroit and was a general practitioner. He was graduated from Wayne State University School of Medicine.

Herman Kanter, MD
Southfield

Detroit-area obstetrician and gynecologist Herman Kanter, MD, died Jan. 7 at the age of 71. He was assistant director of Maybury Clinics, Inc., of Detroit, and was on the staffs of Sinai and Hutzel Hospitals.

Doctor Kanter was a graduate of the University of Michigan Medical School and was a member of the Detroit Surgical Society, Michigan Society of Obstetricians and Gynecologists, and the American College of Obstetricians-Gynecologists.

Robert G. Laird, MD
Grand Rapids

Robert Glover Laird, MD, Grand Rapids ophthalmologist, died Jan. 4 at the age of 72.

Doctor Laird was graduated from the University of Tennessee medical school, and was affiliated with Butterworth, Blodgett Memorial and St. Mary's hospitals in Grand Rapids.

He was a former secretary of the MSMS Section on Ophthalmology.

Wilfrid J. Lewis, MD
Detroit

Wilfrid John Lewis, MD, long-time Detroit-area internist, died Jan. 6 at the age of 73. Doctor Lewis was a graduate of the University of Western Ontario medical school and specialized in cardiovascular diseases.

Doctor Lewis was a native of Ontario and came to Detroit 50 years ago. He was a member of the Michigan and American Societies of Internal Medicine, and the College of Physicians and Surgeons of Ontario.

Walter S. Novak, MD
Port Huron

Walter Stanley Novak, MD, Port Huron physician for nearly 24 years, died Dec. 4 at the age of 60. Doctor Novak had retired in 1971.

He was former chief of the Department of Obstetrics and Gynecology at Port Huron and Mercy Hospitals and was a former chief of staff at Port Huron Hospital. He was graduated from Western Reserve University School of Medicine and also held a master's degree from Wayne State University.

He began practice in Port Huron in 1946 and was a past president of the St. Clair County Medical Society.

He was a fellow of the American College of Surgeons and a diplomate in the American College of Obstetricians and Gynecologists.

Better use
of hospital OB beds
committee report

Michigan Medicine *presents the following report in its entirety, as its contents will have an important bearing on obstetrics as they are practiced in Michigan hospitals in the future.*

The report, of major significance to Michigan physicians and hospitals alike, is being distributed simultaneously by MSMS and the Michigan Hospital Association.

How to provide best care?

A long, hard look at Michigan's OB departments

or
The report of the MSMS Subcommittee on Better Utilization of OB beds

Institutional or community pride and unreasonable physician demands for obstetrical facilities convenient to home and office are all too often the primary justification for the existence of a hospital obstetrical department. In addition, public support for these ill-advised facilities is frequently based on a prevalent misconception that every general hospital must have an obstetrical department to be licensed, accredited or otherwise so recognized.

The result in a number of Michigan communities is unnecessary and costly duplication of facilities and services as well as the perpetuation of smaller, less efficient hospital obstetrical departments that are not conducive to the provision of comprehensive, high quality obstetrical care.

This is harsh criticism! Nevertheless, the Maternal and Perinatal Health Committee of the Michigan State Medical Society has identified hospital or community situations to which this harshness is entirely applicable.

As a result, the Maternal and Perinatal Health Committee established a Subcommittee on Better Utilization of Obstetrical Beds in 1966.

The subcommittee, through its concerted efforts since 1966, has:

- — Brought about certain healthy change and needed improvement in the accessibililty, quality, comprehensiveness and efficiency of hospital obstetrical care.
- — Increased professional and public recognition of the economic and other practical considerations involved in providing hospital obstetrical care.

The subcommittee's role in providing physician initiative and leadership in the planning and provision of hospital obstetrical care not always has been comfortable; occasionally has been viewed with suspicion; and often has met with resistance. On the other hand, there now is greater recognition that it is exceedingly important for the medical profession to provide this initiative and leadership rather than to wait for government, third party intermediaries and others to usurp its prerogatives.

The subcommittee intends this report to serve as a summary of its activities and accomplishments and as a vehicle to present concepts and policies it considers basic to the proper planning and provision of hospital obstetrical care.

Activities and Accomplishments of the Subcommittee on Better Utilization of Obstetrical Beds 1966-1972

The Subcommittee on Better Utilization of Obstetrical Beds was established in 1966 with Arthur C. Rutzen, MD, of Detroit as first chairman. The subcommittee issued its first report January 18, 1967 after considerable study of the factors influencing the utilization and quality of hospital obstetrical care, a number of visits to individual hospitals and consultation with representatives of the Michigan Department of Public Health and others. This report was adopted by the Maternal and Perinatal Health Committee and later approved by The MSMS Council.

A copy of the report, including recommendations for changes in the state licensure standards for hospital obstetrical departments, was transmitted to the MDPH. The direct result was a revision of the State Rules and Minimum Standards for Hospitals as they pertained to hospital obstetrical departments. The revised standards provided:

— A new and broader definition of an obstetrical patient in keeping with the subcommittee's recommendations that the use of obstetrical beds be limited to:

"(a) Any patient who is pregnant, regardless of duration of gestation and including threatened abortions, incomplete abortions, and ectopic pregnancies, etc.

(b) Postpartum patients during the hospitalization immediately following delivery."

— The opportunity for individual hospitals to request and when appropriate to receive MDPH permission to utilize surplus obstetrical beds for clean gynecological patients under controlled conditions. Such permission, granted at the discretion of the MDPH director, should be limited to hospitals that had more than 500 deliveries in the preceding year and a surplus of six or more obstetrical beds. In addition, such permission should only be granted when surplus obstetrical beds cannot be "swung" more or less permanently to another nursing unit or consolidation of obstetrical departments in the community is not considered feasible.

— A new statistical formula to determine the desirable size of a hospital obstetrical department based on the size of the postpartum case load. This formula, determined to be "quite accurate" by the subcommittee, recognized that to accommodate the "peaks and valleys" of demand for postpartum beds, the desirable level of occupancy in the obstetrical department, so far as postpartum mothers were concerned, had to be less than in the hospital's medical-surgical units.

— A renewed emphasis on the desirability of consolidating hospital obstetrical departments in a community consistent with accepted health facility planning principles and policies with the objective that smaller, inefficient or substandard obstetrical departments would be eliminated.

In addition, during 1967 and 1968, members of the Maternal and Perinatal Health Committee and the Subcommittee on Better Utilization of Obstetrical Beds, representing MSMS, participated with other health professionals on an ad hoc committee to advise the MDPH in the development of "Guidelines for Hospital Obstetrical Departments and Newborn Nurseries." This document, incorporating concepts and policies recommended by or acceptable to the medical profession, has received state and national recognition. More recently, the American College of Obstetricians and Gynecologists and a number of health planning agencies have published similar guidelines.

The chairman and members of the subcommittee have worked closely with the MDPH since to evaluate requests from individual hospitals for permission to utilize surplus obstetrical beds for clean gynecological patients.

The impact of the subcommittee's efforts to improve the utilization and quality of hospital obstetrical care in Michigan is demonstrated by the following:

— Thirty-three hospital obstetrical departments with 427 beds ceased to operate during the years 1966-1972. This was concurrent with closing of the hospital in four instances because of serious deficiencies and a failure to comply with state licensure standards.

The subcommittee was pleased to note (although state licensure action is pending against three additional hospitals in this group) that:

— Decisions to close or consolidate hospital obstetrical departments in a number of communities was stimulated and encouraged by practicing physicians influenced by subcommittee efforts.

On its formation in 1966, the Subcommittee on Better Utilization of Obstetrical Beds was directed to:

- Develop a statement on the extent of the problem of non-utilized obstetrical beds in Michigan hospitals
- Make recommendations and develop guidelines for more efficient use of obstetrical beds
- Make recommendations for indicated changes in the state rules and minimum standards for hospitals on which licensure is based

Since then, the committee also has been directed to:

- Provide physician initiative and leadership in the evaluation and resolution of the many and diverse problems that compromise the quality of hospital obstetrical care in Michigan
- Work cooperatively with the MDPH and other public and private agencies concerned with the provision of health care and services to Michigan mothers.

- Many practical advantages, including making beds or space immediately available for other services without a need for new and costly construction, accrued to a number of these hospitals.
- Closing of the obstetrical department had no adverse effect on the hospital's reputation, its state licensure status or its accreditation by the Joint Commission on Accreditation of Hospitals.
- Nine hospitals currently have permission to utilize a total of 97 surplus obstetrical beds for clean gynecological patients in accord with a written plan accepted by the MDPH director. Another hospital, previously granted such permission, recently closed its obstetrical department as the result of successful planning with three other major hospitals in northwest Detroit and southern Oakland County.
- Physician leadership in the planning and utilization of hospital obstetrical services in Michigan has been enhanced.

In 1971, the Maternal and Perinatal Health Committee and its Subcommittee on Better Utilization of Obstetrical Beds received several requests from physicians and others to intensify efforts to provide effective medical leadership and participation in statewide and community planning efforts designed to improve utilization and quality of hospital obstetrical departments. To this end, the membership of the subcommittee was expanded to include representatives of a number of professional organizations and agencies directly concerned with provision of hospital obstetrical care as noted above.

In 1971, the subcommittee received from its parent Maternal and Perinatal Health Committee and the MSMS Council a reaffirmation of support and a commitment of funds from the latter.

This made it possible during the past year for the subcommittee to meet with representatives of selected communities and hospitals to discuss the local planning and provision of obstetrical care. These meetings have given the subcommittee members greater insight into the considerations and problems involved in such planning as well as the manner in which subcommittee efforts can be expected to have a positive impact in individual communities. The subcommittee also is undertaking a public information compaign to acquaint physicians, other health professionals and the general public with the subcommittee's objectives, activities and accomplishments. Most important, subcommittee members have increased their planning expertise and have agreed on the direction of the subcommittee's future activities.

Concepts and Policies Governing the Planning and Provision of Hospital Obstetrical Care

The Subcommittee on Better Utilization of Obstetrical Beds has reached a concensus on certain concepts and policies governing the planning and provision of hospital obstetrical care. These concepts and policies are best presented as responses to a series of questions the subcommittee is called upon from time to time to answer.

1. *Should hospital obstetrical care be provided in segregated obstetrical departments and admissions to those departments be restricted to individuals meeting the definition of an "obstetrical patient"?*

The subcommittee's answer is a qualified "yes."

There is no question that obstetrical beds can be used for non-obstetrical patients with safety *under carefully controlled conditions.*

However, it is the subcommittee's judgment that the potential for such "careful control" does not uniformly exist in all or even a majority of Michigan hospitals licensed to provide obstetrical care. This judgment is based on the personal experience and observation of individual subcommittee members that there are wide variations in the quality and effectiveness of hospital governing bodies, administrators and medical staff organizations who would have to be responsible for assuring such "careful control."

Therefore, the subcommittee strongly supports the concept of segregated obstetrical departments and a restriction on admissions to "obstetrical patients" in order to focus the concern of hospital governing bodies and administrators on an important group of patients with unique needs while limiting the responsibility for care of patients in the obstetrical department to physicians intimately concerned with their welfare.

On the other hand, the subcommittee qualifies its position to the extent that it recommends broadening the definition of an "obstetrical patient." Thus, hospitals might place pregnant women at any stage of gestation, including ectopic pregnancies, threatened and incomplete abortions in obstetrical beds not immediately required for care of postpartum mothers. The subcommittee assumes that in a majority of instances these patients also would be cared for primarily by the hospital's obstetrical staff.

2. *Should any hospital be permitted to utilize surplus obstetrical beds for non-obstetrical patients?*

The subcommittee's answer is a qualified "yes."

The subcommittee recognizes that it is feasible and proper to permit selected hospitals to care for non-obstetrical patients in their segregated obstetrical departments when a surplus of beds exists. However, such permission should only be granted by the state licensing agency when:

- The hospital has a *significant* utilization problem in terms of surplus obstetrical beds.
- The hospital can provide effective continuing medical and administrative control over the use of surplus obstetrical beds by non-obstetrical patients.
- The utilization of surplus obstetrical beds for non-obstetrical patients does not negate incentives to the community and the hospital to:
  - (1) Consolidate obstetrical departments in the community.
  - (2) "Swing" surplus obstetrical beds to another nursing unit within the hospital on a more or less permanent basis.
- The non-obstetrical patients admitted to surplus obstetrical beds are limited to clean gynecological patients primarily under the care of physicians for the most part already members of the obstetrical staff and most intimately concerned with the welfare of patients in the obstetrical department.

3. *How is the bed need for a hospital obstetrical department determined?*

The subcommittee accepts certain assumptions about the planning and operation of hospital obstetrical departments:

- The postpartum suite is part of a segregated hospital obstetrical department. Therefore, in order to assure maximum use, the number of postpartum beds should be limited to the *minimum* number required to accommodate the anticipated case load of postpartum patients admitted to the suite following delivery.
- The number of postpartum beds should be adequate to assure beds for postpartum patients at least 99 percent of the time.
- The number of postpartum beds required to accommodate the anticipated postpartum case load can be estimated with accuracy using the following formula:

$$\text{ADC - PP (Average Daily Census — Postpartum)} = \frac{\text{Number Mothers Delivered Annually (livebirths and stillbirths)} \times \text{Average Length Postpartum Stay}}{365}$$

then,

$$\text{Postpartum Beds} = \text{ADC-PP} + 2.33\sqrt{\text{ADC - PP}}$$

This method of estimating postpartum bed need provides the necessary margin for peak periods of patient occupancy and is determined by the subcommittee to be accurate and useful in actual practice. On the other hand, it is recognized that the average daily census of postpartum patients in a properly used obstetrical department will result in an average postpartum occupancy rate of 45-75 percent which is significantly less than the 85 percent or greater occupancy rate that would be considered desirable in the medical-surgical nursing units.

Consolidation of hospital obstetrical departments in a community is conducive to economy of care. For example, in one Michigan community, there were four hospitals with a total of 140 obstetrical beds operating at a combined average occupancy of 56 percent. This meant that, on the average, 79 beds were filled and 61 beds were empty.

If one assigns an arbitrary but reasonable per diem cost of $70 to the occupied bed and $45 to the empty bed, the bed and cost reductions resulting from consolidation of the four hospital obstetrical departments into three departments is demon-

	1967 FOUR HOSPITALS		1970 CONSOLIDATION TO THREE HOSPITALS		REDUCTIONS		
	Avg. No. of Beds Per Day	Annual Cost in $1,000	Avg. No. of Beds Per Day	Annual Cost in $1,000	Beds	Annual Cost in $1,000	%
Filled Beds @ $70	79	$2,018	76	$1,942	3	$ 76	3.7
Empty Beds @ $45	61	$1,002	21	$ 345	40	$657	65.7
TOTAL	140	$3,020	97	$2,287	43	$733	24.3

strated by the following computations.

(It should be noted that the cost of an empty obstetrical bed is made up of indirect fixed costs allocated to each bed and direct staffing costs related to the total unit.)

Thus, consolidation of departments and elimination of 43 obstetrical beds in this metropolitan area might be expected to result in a combined average postpartum patient occupancy of approximately 78 percent and an overall reduction in cost of $733,000 per year. On a lesser scale, the same desirable results might reasonably be expected from consolidation of smaller obstetrical departments.

4. *What is the extent of the problem with respect to surplus obstetrical beds in Michigan hospitals?*

The subcommittee, assisted by the Michigan Department of Public Health, developed the following data based on the 1971 record of deliveries in individual hospitals and the licensure status of hospitals on Oct. 1, 1972.

Bed Size of Obstetrical Department	Total Facilities	License Equals PP Bed Need	Hospitals with Insufficient Beds		Hospitals with Surplus Beds		Total Surplus Beds
			1-5	6 or more	1-5	6 or more	
Totals	180	28	48	9	66	29(-9)*	466(-97)*
1-5	30	13	10	1	6	0	8
6-10	51	11	19	0	21	0	48
11-15	21	3	2	0	15	1	52
16-20	18	1	8	1	5	3	43
21-25	15	0	4	3	7	1(-1)	28(-6)
26-30	14	0	2	1	6	5(-1)	59(-7)
31 or over	31	0	3	3	6	19(-7)	217(-84)

*Numbers in parentheses indicate facilities and surplus beds authorized for admission of clean gynecological patients.

In summary, the problem of surplus obstetrical beds exists in 95 hospitals where there are an estimated 466 such beds, an average of less than five surplus beds per facility.

Nine of these hospitals have been granted permission to utilize 97 of the surplus beds for clean gynecological patients reducing the average number of surplus beds to about four per facility.

The extent of the problem is further tempered by the fact that the remaining 20 hospitals with six or more surplus beds either have not applied for permission to utilize these beds for clean gynecological patients or have been denied permission because consolidation of obstetrical departments in the community or "swinging" of surplus obstetrical beds permanently to another nursing unit within the same facility is feasible.

It also must be kept in mind that this estimate of surplus beds is calculated on the basis of the 1971 case load of postpartum patients and a four day average postpartum stay. In hospitals where the postpartum stay is, on the average, longer than four days or there are significant numbers of patients with complications admitted prior to delivery or retained longer after delivery, the *actual* number of surplus beds may be significantly decreased from the estimated number cited above. On this basis, at least five of the hospitals estimated to have six or more surplus obstetrical beds did not actually have a significant utilization problem.

Attention is further directed to the fact that there are a number of hospitals with an insufficient number of postpartum beds. In some of these hospitals, overcrowding is a serious problem and the MDPH is working actively with these facilities to solve that problem. On the other hand, certain of these hospitals are able to accommodate their case load by shortening the postpartum stay and utilizing selective early discharge when necessary.

On the basis of the above, it is the subcommittee's position that the problem of surplus beds is not a major problem statewide but may still be a significant problem in individual hospitals. However, it may be necessary to modify this position somewhat if the decrease in total annual births in Michigan continues at the present rate.

There were approximately 15,000 fewer births in Michigan during 1972 than in the preceding year. This conceivably could have reduced the demand for postpartum care by as much as 60,000 patient days which is equivalent to reducing the average daily census of postpartum patients in hospitals by approximately 165 statewide.

The effect of this decreased demand for obstetrical beds on individual hospitals remains to be determined. On the other hand, the decrease in bed need averages less than one per licensed obstetrical department. Therefore, it is reasonable to conclude that the undesirable pressure for beds in the 57 hospitals with an inadequate number of obstetrical beds has been reduced while the utilization problem in hospitals with surplus obstetrical beds has not been seriously aggravated.

5. *Is there a positive correlation between the size of the hospital obstetrical department and the quality of care?*

The subcommittee's answer is "yes."

The "Guidelines for Hospital Obstetrical Departments and Newborn Nurseries" published by the Michigan Department of Public Health state "A hospital obstetrical department and newborn nursery should ideally provide services for at least 2,000 mothers and their infants annually. Such a desirable case load is conducive to quality, efficiency and economy of care."

The "National Needs in Obstetrics and Gynecology — 1971" published by the American College of Obstetricians and Gynecologists states "Data obtained from the ACOG National Study of Maternity Care indicate that full hospital obstetric services, in terms of use of beds, personnel and facilities for the care of all kinds of obstetric complications, can only be provided efficiently when more than 1,500 deliveries occur per year.

"In more sparsely populated communities limited but adequate service can be provided with reasonable efficiency when at least 500 patients are delivered at the hospital per year; below this number efficiency is decreased." As a result, the American college recommended "Hospital obstetrical services should be consolidated. In larger communities (100,000 population or more), more than 1,500 deliveries should occur yearly in each unit. In smaller communities (30,000 population or more), more than 500 deliveries should occur annually in each unit. In rural areas, obstetrical services should be coordinated and consolidated as much as possible."

These recommendations are intended to enhance the quality, efficiency and economy of obstetrical care.

Obviously the larger obstetrical service is conducive to:

- Proper administrative and medical control of the obstetrical department, the latter through effective medical staff organization and functioning.
- Effective appraisal of the work done in the obstetrical department and the enforcement of hospital policies and rules applicable to that department.
- Conservation of the physician's time and effort in provision of care and medical administration.
- Development of inservice training programs for physicians, nurses, and other specialized or ancillary service staff involved primarily in the care of mothers and their newborn infants or the day-to-day maintenance and operation of the department.
- Acquisition, availability and maintenance of equipment and stocks of supplies required for quality obstetrical care.

An analysis of information from the Michigan Maternal Mortality Study, a joint project of the Maternal and Perinatal Health Committee and the MDPH confirms the above statements that larger obstetrical departments are conducive to better obstetrical care.

Hospital related maternal deaths due to direct obstetric causes in pregnancies of 20 or more completed weeks gestation were reviewed for the period 1966-1971. These deaths were categorized by size of obstetrical service based on the average annual number of livebirths as well as their association with avoidable factors which were the responsibility of the attending physician, consultant or hospital. A maternal death was considered hospital-related if it occurred following the patient's admission to the hospital. The results of the review are summarized in **Table 1.**

It is of particular interest to note that:

- The lowest maternal mortality rate and lowest percentage of deaths associated

Hospital Related Maternal Deaths Due to Direct Obstetrical Causes in Pregnancies of 20 or More Completed Weeks Gestation 1966-1971

				Total Maternal Deaths			Associated with Avoidable Factors		
Size Obstetrical Service (Average Annual Livebirths)	Number of Hospitals	Total Livebirths 1966-1971	Percent All Livebirths	Number Maternal Deaths 1966-1971	Percent All Maternal Deaths	Rate Per 10,000 Livebirths	Number Maternal Deaths	Percent Assos. Avoid. Factors	Rate Per 10,000 Livebirths
1-500	121	146,529	15.06	29	18.83	1.98	26	89.65	1.77
(1-100)	(24)	(7,074)	(0.73)	(3)	(1.95)	(4.24)	(2)	(66.67)	(2.83)
(101-500)	(97)	(139,455)	(14.33)	(26)	(16.88)	(1.86)	(24)	(92.30)	(1.72)
501-1,000	32	131,718	13.53	20	12.99	1.52	15	75.00	1.14
1,001-2,000	38	310,956	31.95	53	34.42	1.70	40	75.47	1.29
2,001 or more	22	382,049	39.46	52	33.76	1.35	37	71.15	0.96
TOTAL	213	973,252	100.00	154	100.00	1.58	118	76.62	1.21

TABLE 1. Hospital related maternal deaths due to direct obstetric causes in pregnancies of 20 or more completed weeks gestation by size of hospital obstetrical service based on average annual livebirths 1966-1971 and association with avoidable factors.

with avoidable factors occurred in hospitals averaging 2,001 or more livebirths annually.

— The highest maternal mortality rate and highest percentage of deaths associated with avoidable factors occurred in hospitals averaging 500 or fewer livebirths per year.

— 121 hospitals (56.8 percent of the 213 hospitals operating an obstetrical department during the period 1966-1971) averaged 500 or fewer livebirths annually and accounted for only 146,529 livebirths (15.1 percent of the total livebirths).

The fact also was established that two or more of these smaller obstetrical departments frequently served the same community or duplicated the facilities and services of a larger department in the same community. Therefore, if one accepts the rather obvious conclusion that larger hospital obstetrical departments are more conducive to quality, efficiency and economy of care, especially when comparable services are considered, there is considerable opportunity and justification for further consolidation of hospital obstetrical departments in Michigan.

Fetal and perinatal deaths (as defined by the MDPH) for 1970 are under review with respect to the size of the hospital obstetrical department and will be the subject of a subsequent report. However, preliminary information indicates:

— The fetal mortality rate was significantly higher in hospitals that had no more than 100 total births.

— The hospitals that had a fetal mortality rate greater than 20.0 per 1,000 births (as compared to the state average of 12.0) have significantly fewer deliveries — 455 per year on the average — than all other hospitals with a licensed obstetrical department.

6. *What is the recommended minimum size for a hospital obstetrical department?*

The subcommittee takes the position that no hospital obstetrical department should exist unless it cares for more than 500 deliveries annually.

The only exception to this position is that a smaller department may *occasionally* be justified in Michigan on the basis of a community's geographic isolation.

This position is supported by the disproportionate number of maternal and fetal deaths that occur in hospital obstetrical departments serving less than 500 mothers and their infants annually. It is further supported by equally important economic and other practical considerations noted above.

The subcommittee, in evaluating the accessibility of hospital obstetrical departments for patients and physicians, utilizes the standard of one-half hour travel time by automobile as being reasonable and acceptable. This is in contrast to the American College of Obstetricians and Gynecologists which uses the standard of one hour travel time and other recognized authorities who utilize the standard of 45 minutes travel time.

7. *Is the development of regionalized centers for the care of high risk mothers and infants desirable?*

The subcommittee's answer is "yes."

The Maternal and Perinatal Health Committee, MSMS, and the American College of Obstetricians and Gynecologists not only support the concept of consolidation of hospital obstetrical departments in communities, but, in addition strongly support the concept of regionalized centers for the care of high risk mothers and infants. Such regionalization justifies the availabililty of specialized physician services — both obstetric and pediatric; around-the-clock specialized nursing care and techniques; necessary facilities and monitoring equipment as well as complex technical laboratory, x-ray, blood bank and other necessary services.

Subcommittee Plans for the Future

The subcommittee plans for future activities are flexible in order to permit sufficient leeway for a variety of coordinated courses of action. In general, however, the subcommittee plans to continue its efforts to:

— Work with physicians, primarily through the county medical society structure, the Michigan Hospital Association, health planning agencies and individual hospitals,

Following are the members of the MSMS Subcommittee on Better Utilization of Obstetrical Beds:

Harrison C. Visscher, MD, Grand Rapids, Chairman

Charles J. Berger, MD, Lansing
John W. Hallitt, MD, Flint
Richard T. Mellis, MD, Kalamazoo
Lee B. Stevenson, MD, Detroit
Hermann A. Ziel, Jr., MD, Lansing

Organizational Representatives

Sydney C. Peimer, Michigan Hospital Association
John Newton, Michigan Hospital Association
Herbert A. Auer, Michigan State Medical Society
Paul P. Mitros, DO, Michigan Osteopathic Hospital Association
Charles K. Norton, DO, Michigan Association of Osteopathic Physicians and Surgeons
William C. Stewart, Jr., MD, Michigan chapter, American Academy of Pediatrics
Duane M. Allen, MD, Michigan Academy of Family Physicians
Harold Tremain, MD, Michigan Hospital Service

Here's a brief analysis of Phase III impact on physicians

MSMS members with questions about Phase III of the federal economic stabilization program are invited to write or phone MSMS for answers and assistance. Warren Tryloff, MSMS director, invites members to contact John Anthony, chief, MSMS Bureau of Economic Information.

One of the major changes was the federal decision that doctors do not need a fee schedule any longer for public inspection. Doctors do not need to post a sign any longer saying such a schedule is available.

Following is a brief description of the conditions under Phase I, II and III, and short description of some of the Phase III guidelines still in effect:

There have been three phases of economic guidelines for the U.S. economy. The first phase, August 15, 1971, froze all earners' salaries and all commodity and service prices. Three months later, Phase II was enacted.

Phase II, November 14, 1971, established fixed standards for both wages and fees. These standards were controlled and enforced with few exceptions. At that time, the AMA and MSMS opposed the unfair, discriminatory actions of the Price Commission.

Phase III, January 11, 1973, imposes voluntary restrictions on wages, rents, fees, and prices except in certain industries. The health care industry must still conform to the guidelines that were in effect under Phase II controls. Once again, the AMA and MSMS have voiced their dissent over this obvious discriminatory action.

Following are some of the guidelines that still affect physicians:

1. Physicians are held to fees in effect on November 14, 1971. Any increases in fees up to a maximum of 2.5% must be justified on the basis of allowable cost (overhead) increases. Such increases are permissible only if they don't increase the doctor's profit margin (the difference between the practice's gross income and net income) and only to the extent they are not offset by increased productivity.

2. Physicians who have not increased their fees since January 1, 1971, may be eligible to raise them by a cumulative 5%, effective January 1, 1973. Physicians are permitted to increase fees 2.5% annually without seeking prior approval by the IRS. Physicians cannot increase their profit margin above the base period. Base period profit margin is defined as any two of a physician's past three fiscal years ending before August 15, 1971.

3. Incorporated physicians' salaries (including benefits) cannot be increased more than 5.5%. Exempt from the 5.5% ceiling are automatic or planned "longevity" increases in salaries for physicians in medical corporations, provided this salary plan existed before November 14, 1971. But, the corporation is restricted to the 2.5% fee guidelines.

4. Those physicians who feel that they have suffered a gross inequity or serious hardship may apply for an exception to the regulations. They should use forms S-16 and S-53 for this purpose. Requests for exceptions to the guidelines may be directed to:

District Director
Economic Stabilization Program of the IRS
2011 Park Avenue Bldg., Detroit, Michigan 48226

The MSMS Bureau of Economic Information is collecting all regulations and rulings pertaining to the Economic Stabilization Programs that affect the health care industry.

OB BED UTILIZATION/Continued

to improve the quality, availability and utilization of obstetrical care. In part, this will be done by promoting the concept of consolidation and/or regionalization of obstetrical departments with elimination of those that are smaller or substandard in the quality of care provided.

— Promote and be a catalyst in the development of more effective hospital obstetrical departments through consultation services to obstetrical staffs and administrators of individual hospitals.

— Develop an educational program for providers and consumers of hospital obstetrical services so that there is more general understanding of health planning policies and concepts related to the delivery of such services.

— Work with individual hospitals and communities in resolving problems compromising the accessibililty, quality, comprehensiveness and efficiency of obstetrical departments and services. In this effort, an attempt will be made to encourage physicians to take a leadership role in the planning, operation and financing of hospital obstetrical departments in their respective communities.

— Work with the MDPH, to assure that the standards for hospital obstetrical departments are appropriate and conducive to quality, effectiveness and economy of care.

The subcommittee will henceforth submit at least an annual report of its work, accomplishments and position on pertinent matters to its parent Maternal and Perinatal Health Committee, of MSMS.

President's page

(This month, Doctor Coury invites Brooker L. Masters, MD, Fremont, MSMS president-elect, to express his views through a President's Page article.)

Let me describe the puzzling situation that I find as I visit with various component societies across Michigan.

Doctors, along with society in general, find everything in a turmoil. Our youth are reacting against their parents. The "new morality" as well as the "new math" shake up the adult population. Many young people are reacting against such traditional virtues as "patriotism" and "loyalty." "Initiative" and "free enterprise" are regarded in many places as dirty words.

Our sets of values, our traditions are being upset.

Physicians may be the most perplexed of the lot. We chose to be doctors because it would afford us the chance to think, to be independent, to serve our fellow man.

And now we face the increasing pressures of governmental controls, new directives almost every day from some agency or perhaps the hospital administrator.

As doctors we complain about the frequent attacks upon our integrity.

Some of the leaders in government and legislation seem to be joining labor leaders to argue that the medical organizations are opposed to progress and change.

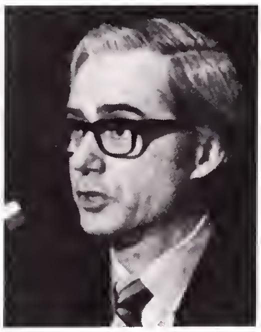
Health planners tend to veiw any change as an improvement; and because of our medical training we know that ain't necessarily so.

Perhaps doctors have *never* been so restless, so confused, so displeased with what they see about them.

To me this seems odd, so unfortunate. Let me explain . . . :

While we grump and gripe, we find the following situation to be true . . .

1. The 1972 Gallup poll shows as it did in 1971 that doctors are held in higher regard today than any other profession or occupation by the public.
2. Physicians enjoy relatively more freedom of action and decision making than any other profession or business.



Brooker L. Masters, MD
MSMS president-elect

3. And physicians' incomes are at an all-time high; in the upper half per cent of the national family income.

Let me tick off some of the other good conditions that exist today for doctors in Michigan and the nation . . .

4. Organized medicine today has found new desires to work for unity and solidarity. MSMS has more members now than ever in our history.
5. Young people continue to clamor to get into medical schools.
6. Interns and residents are joining the AMA in numbers like never before.

So can you tell me why it is that some physicians seem to be unhappy with their component medical society, with MSMS, or with the AMA . . . when many conditions really are great for us?

I know these are indeed times of change and I know too that changes seem to be coming faster than ever.

But the only effective way that individual doctors can deal with any of the disturbing factors is through our medical societies.

Individually, we are almost powerless; collectively we really do not know our total strength.

When doctors complain to me about the AMA, I ask them, "Who would speak up for us if there was no AMA?"

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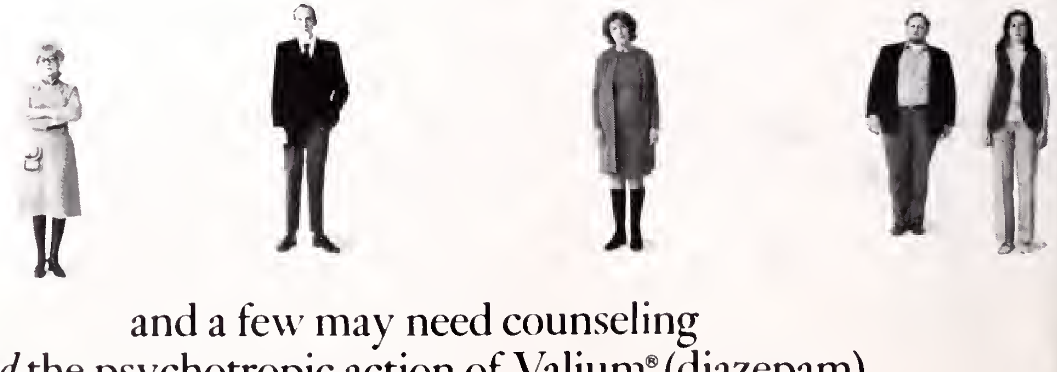

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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

State Rep. Charles Varnum (R., Manistique) discusses health legislation in Lansing with Mary Cretens, MD, director of the Delta County Public Health Department. Doctor Cretens met with Rep. Varnum and many other state legislators as part of the Michigan State Medical Society's "Doctor of the Week" program, in which practicing physicians spend a week each in the Capitol Building becoming acquainted with the legislative process and providing medical information to members of the legislature.

'Doctors of the Week' set to visit Lansing, legislature

Seventeen Michigan physicians are scheduled to spend one week each in Lansing during the current legislative session, which runs Feb. 13-June 29. They have joined the MSMS Doctor of the Week Program.

But there still are openings late in March, early in May and late in June when interested doctors may stay four days in the Capitol City visiting legislators and offering the physician's viewpoint on key medical issues.

Each doctor arrives at the MSMS building about 10 a.m. on the Tuesday morning of his week. He stays in room 429 of the Olds Plaza Hotel, across from the Capitol Building, and ends his sojourn at noon on Friday.

Those participating are Walter D. Meester, MD, Grand Rapids; Gerald I. Maas, MD, Jackson; Charles E. Conaway, Lapeer; Lionel E. Dorfman, MD, Battle Creek; Charles H. Willison, MD, Midland; Charles L. Oppy, MD, Roscommon; and Jimmy Mistry, MD, Monroe.

Also Thomas A. Barton, MD, Howell; Mary Cretens, MD, Escanaba; Osbie J. Herald, MD, Muskegon; Henry A. Kallet, MD, Jackson; Charles E. Black, MD, Monroe; Paul T. Lahti, MD, Royal Oak; F. P. Rhoades, MD, Detroit; Joel Kriegel, MD, Mt. Clemens; Robert E. Paxton, MD, Fremont, and Eber B. Sherman, MD, Eaton Rapids.

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Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.
Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.
Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or at every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.
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Small doses

Lowell E. Blanchard, MD, Hudson,
who has served his community as family doctor for 40 years, was honored recently with a testimonial dinner. Included were resolutions of tribute from the Lenawee County Medical Society, read by Doctor Blanchard's son-in-law, Richard Gascoigne, MD, past LCMS president; and from MSMS, read by James Gascoigne, MD, Doctor Blanchard's partner and a brother of Richard. The Michigan Senate and House of Representatives passed a concurrent resolution on Dec. 11 honoring Doctor Blanchard.

Ralph Blocksma, MD, Grand Rapids,
is chairman of the board of Medical Assistance Programs, Inc., which recently sent $500,000 worth of vaccines and foodstuffs to the earthquake victims of Managua, Nicaragua. Doctor Blocksma received a letter in December from President Richard Nixon praising MAP for its emergency assistance to Bangladesh, an earlier MAP project.

B. P. Brown, MD, Charlotte,
has retired following 10 years as health officer of the Barry-Eaton-Ionia District Health Department. Prior to that Doctor Brown, who is spending the winter in Florida, was in private practice for 30 years.

Dwight J. Dutcher, MD, Grosse Pointe,
is a new member of the Bon Secours (Grosse Pointe) Hospital Board of Trustees.

William F. Fidler, MD, Pontiac,
is acting director of the Oakland County Health Department, following the resignation Jan. 1 of Bernard Berman, MD, director.

Theodore Goldberg, MD, Huntington Woods,
is head of a Wayne State University School of Medicine project to promote reform of medical care in penal institutions. The project is the recipient of a $5,000 grant from the Ford Foundation.

Robert C. Horn, Jr., MD, Detroit,
is new president-elect of the College of American Pathologists. Doctor Horn will be installed as president at the CAP's next annual meeting in the fall of 1973.

James J. Lightbody, PhD, Detroit,
son of the former MSMS president, is director of an in vitro study of cell mediated immunity to tumor that has been awarded a $48,283 grant by the American Cancer Society. Doctor Lightbody is assistant professor of biochemistry in the Wayne State University School of Medicine.

Paul Lowinger, MD, Detroit,
of the Wayne State University School of Medicine faculty, has been nominated by petition for the position of president-elect of the American Psychiatric Association. He represents the Radical Caucus of the APA.

Brooker L. Masters, MD, Fremont,
MSMS president-elect, is new medical examiner for Newaygo County. Doctor Masters was nominated for a four-year term beginning Jan. 1.

Franklin D. McDonald, MD, Detroit,
is new chief of the Section of Nephrology at Hutzel Hospital and chief of the Division of Nephrology in the WSU Department of Medicine.

Donald N. Sweeny, Jr., MD, Detroit,
chairman, MSMS delegation to the AMA, is a new member of the board of the National Association of Blue Shield Plans.

John Tanton, MD, Petoskey, and George D. Maniaci, MD, Gladstone,
have been appointed by the governor to two state bodies. Doctor Tanton is a member of the Wilderness and Natural Areas Advisory Board, while Doctor Maniaci continues as a member of the State Advisory Council on Mental Health Services.

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Total hip replacement in a community hospital

By Alfred B. Swanson, MD, FACS
Norman R. Boeve, MD
Thomas G. Wadsworth, M Ch Orth, FRCS
Grand Rapids

The first recorded total hip replacement was performed by Wiles in England in 1938.[9] In 1951, Haboush performed the first total hip replacement in the United States.[4] This was also the first recorded use of fast-setting dental acrylic for fixation of the prosthetic components. At the suggestion of Wiltse,[10] whose basic methyl methacrylate research focused attention on using acrylates for the bonding of prosthesis, Charnley used self-curing acrylic cement to anchor a femoral head prosthesis in 1958.[1] A short time later, Charnley began using a total hip prosthesis of his own design with acrylic cement as the bonding agent.[2] The Charnley stainless steel femoral component has a 22 millimeter head and a high density polyethylene cup.

McKee and Watson-Farrar designed their first total hip replacement prosthesis in 1951. They began using acrylic cement in 1960 and, after several design changes, produced the prosthesis currently in use.[6] The chrome-cobalt McKee-Farrar prosthesis is composed of a Thompson design femoral head with a matched metallic cup. The head is available in 1-3/8 inch and 1-5/8 inch diameters and there is a long or a short neck.

More recently several orthopaedists have introduced hip joint prosthesis using different designs and materials.[7,8] Total hip replacement rapidly became a very popular procedure in Europe and now is in the United States.

In the Charnley, McKee-Farrar and Müller prosthesis, methyl methacrylate cement is used for fixation of the prosthetic components. The cement is not an adhesive, but rather forms a mechanical interlock, bonding the prosthesis to the patient's acetabulum and femur. The self-curing acrylic cement is formed by mixing a powdered polymer and a liquid monomer into a pliable paste. This then hardens in about 10 minutes into an inert solid composed of long chain polymers. The polymerization reaction is catalyzed by benzoyl peroxide and is exothermic. The powder is sterilized by gamma irradiation and the liquid by passing it through a bacterial filter.

Until recently the Food and Drug Administration had released methyl methacrylate cement only as an investigational drug. To test the safety and efficacy of the cement, they selected 29 clinics in the U.S. to participate in a prospective study. Our clinic was part of this study group and all patients included in this report were done while the cement restrictions were in force. To comply with study requirements, each patient received a detailed history and physical, x-ray (chest, lumbosacral spine, pelvis, hips and knees) and laboratory examination (CBC, ESR, RBC, SMA1260, SMA 660, PSP, Cephalin Flocculation and urine analysis). These studies were repeated at intervals postoperatively.

The cement is now available for general use. The past restrictions on its investigational status have limited its use in the United States. Total hip replacement has nonetheless gained tremendous popularity in this country. The enthusiastic acceptance of this procedure has been paralleled by few new orthopaedic procedures in the past.

Material

At Blodgett Memorial Hospital, we have performed a total of 72 total hip replacements on 65 patients. Sixty-nine hips received a McKee-Farrar prosthesis and the Charnley prosthesis was used in three hips. These were performed between October 20, 1969, and May 12, 1971. Since then we have performed an additional 100 procedures with satisfactory results using McKee, Müller and Charnley implants. The results of these will not be included in this report because the follow-up is less than one year. They are part of a prospective study.

The average age of the patients was 58.2 years. The diagnosis in the 72 cases is shown in **Figure 1.**

The clinical evaluation of each patient included an Analysis of Hip Function after the method of Harris.[5] The average pre-operative score was 30.9 with a range of one to 64.

In 67 of the 72 hips, the patient's primary complaint was pain, and in five the primary complaint

Scientific articles

The authors are with the Orthopaedic Surgery Department, Blodgett Memorial Hospital, Grand Rapids.

DIAGNOSIS	NUMBER
Osteoarthritis	27
Rheumatoid Arthritis	18
Post Traumatic Arthritis	12
Congenital Dysplasia	7
Rheumatoid Spondylitis	3
Juvenile Rheumatoid	3
Aseptic Necrosis	2
	72

Figure 1: Diagnosis of 72 consecutive total hip replacements.

COMPLAINTS	NUMBER
Pain Only	30
Pain and Loss of Motion	30
Pain and Deformity	7
Loss of Motion and Pain	4
Loss of Motion Only	1
	72

Figure 2: Primary presenting complaint in 72 hips.

PAIN SEVERITY	NUMBER
Disabling	7
Severe	49
Moderate	13*
Mild	2*
None	1*

*4 of 13 with moderate pain, both hips with mild pain and the one with no pain all had bilateral complaints.

Figure 3: Indication of pain severity in all hips.

PREVIOUS PROCEDURES	
Prosthesis	15
Cup	13
Pins or Nail	7
Osteotomy	4
Bone Graft	2
Hanging Hip	2
Attempted Fusion	1
Unknown Childhood Procedure	3
	47

Figure 4: Distribution of the 47 previous procedures performed on 28 patients.

COMPLICATIONS	HIPS
Elevation of Greater Trochanter	8
Fatal Pulmonary Embolus	1
Dislocation (reduced)	1
Superficial Infection (opened and irrigated)	2
Diffuse Cellulitis (one patient bilateral)	2
Sterile Drainage (all cleared)	3
Hematoma (drained and healed)	1
Cerebral Vascular Accident (intraoperative)	1
Thrombophlebitis (8 weeks postoperative)	1
Transfusion Reaction (mild)	1
Urethral Obstruction Requiring TURP	1
	22

Figure 5: Total complications in the 72 operated hips.

was limitation of motion. Usually there was a combination of complaints. The patient complaints are detailed in **Figure 2.** Pain was considered to be disabling or severe in 56 of the 72 hips. Patients with lesser degrees of pain and patients with significant limitation of motion complaints, tended to have bilateral involvement. See **Figure 3.**

Twenty-eight of the 65 patients had undergone previous surgery. Fifteen of the hips had had one procedure, eight had had two procedures, four had had three procedures, and one had had four procedures for a total of 47 previous operations. The type of surgery is outlined in **Figure 4.**

A significant number of patients presented with some type of deformity or limitation of motion. Twenty-three hips had flexion contractures of less than 30°, while 27 hips had flexion contractures of 30° or greater. Nine hips had adduction contractures of 10° or greater, and 13 hips had external rotation contractures of 10° or greater.

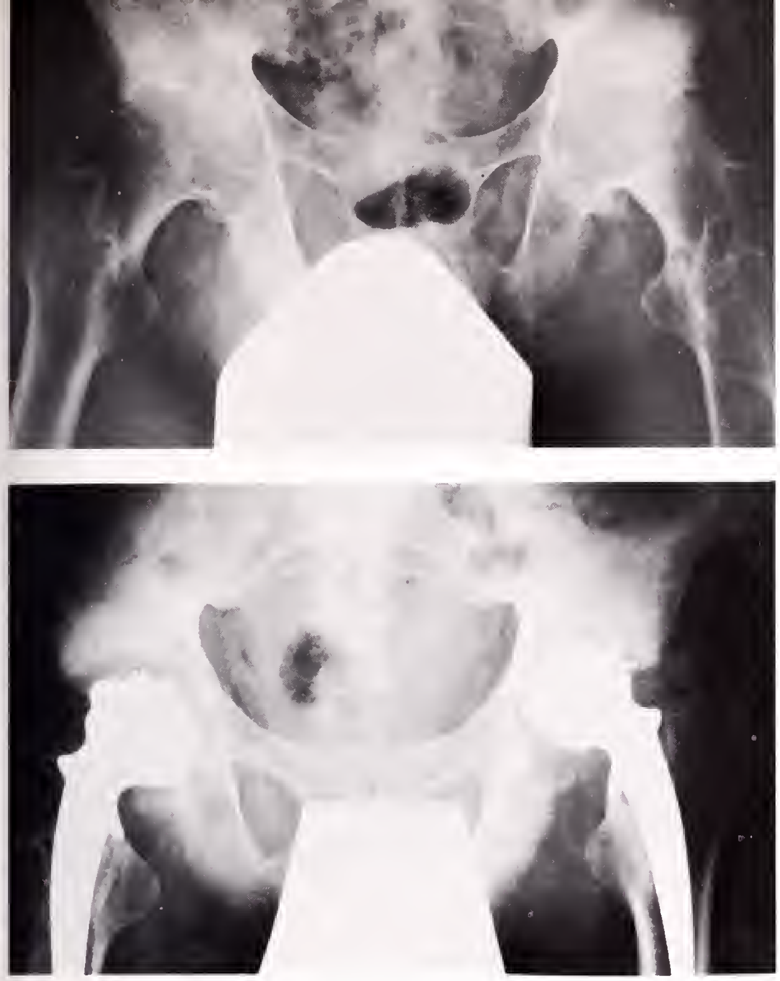

Figure 6:
Case D.B.
Pre and
postoperative
x-rays.

Procedure

Since at the time of this study the methyl methacrylate cement was not released for general use by the Food and Drug Administration, an informed consent and release of liability was signed by the patient. For the McKee-Farrar prosthesis, the hip is approached through an anterolateral incision. We prefer not to remove the greater trochanter where this is surgically feasible. A capsulectomy is performed, the femoral neck is transected and the head discarded. The acetabulum is reamed and prepared with several diverging 3/8-inch drill holes to accept the cement. The femoral canal is broached. After a trial reduction with the matched components, they are individually placed and secured with the cement. The cup is positioned with 30° of inclination and 0° to 10° of anteversion. The femoral component is positioned with 0° to 10° of anteversion. After reduction of the hip, the greater trochanter is advanced and reattached. The incision is closed over a hemovac drain. During the surgery, the wound is irrigated several times with a triple antibiotic solution composed of Polymyxin, Bacitracin and Neomycin.

A lateral approach is used for the Charnley prosthesis and the greater trochanter must be osteotomized. After removing the femoral head, the acetabulum is deepened. The prosthetic components are cemented in position and the greater trochanter is reattached laterally and distally.

The post-operative routine included Keflin for five days. We also use Clinical Dextran for prophylaxis against thrombo-embolic disease until the patient is fully ambulatory. The patient is placed in Buck's traction with the hip in abduction for five days. During that time he has an intensive program of general isometric and selected active exercises. After two days of transfer activity, he begins partial weight-bearing gait training. The status of the greater trochanter dictates the time before support-free ambulation.

Results

The results generally have been encouraging. No patient has complained of actual post-operative pain of any significance greater than a mild degree. No patient has been made worse by this procedure, and no one that we know of has been dissatisfied. Hip function scores were determined on 56 of the 72 operated hips. The mean and average scores post-operatively were 81. The average pre-operative score was therefore raised from 30.9 to the post-operative score of 81. The majority of the points gained was in the pain category. Other points were generally gained by discarding external support and improvement of gait. The average follow-up at the time of determining the post-operative score

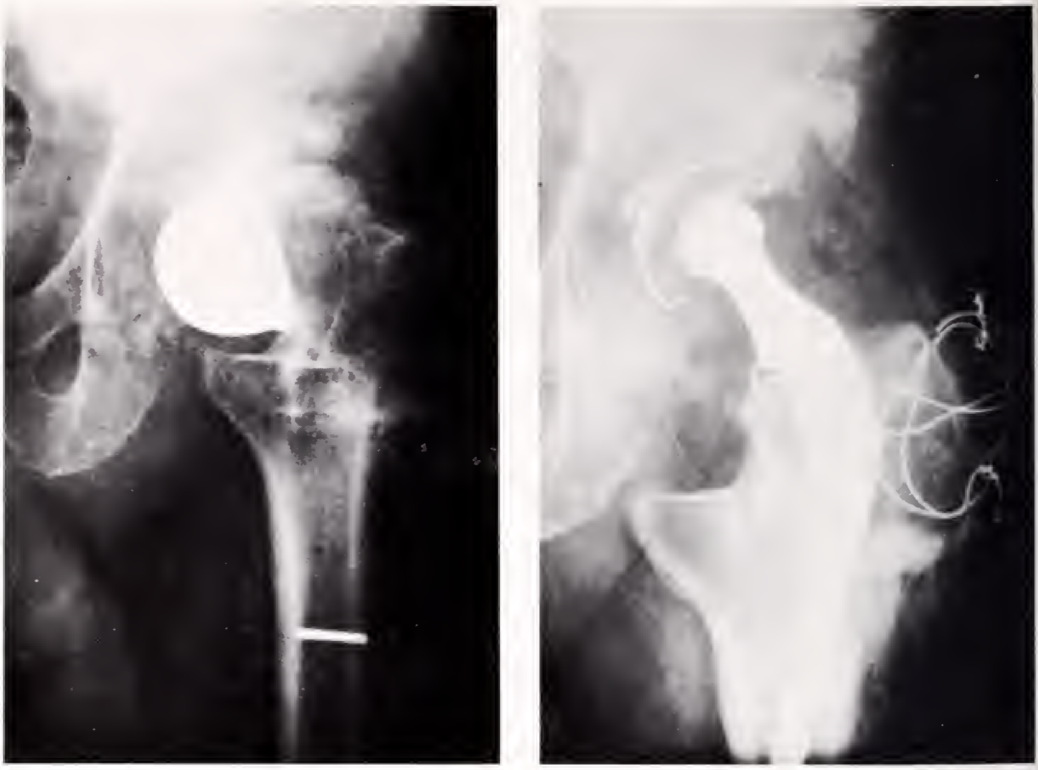

Figure 7: Case R.B. Pre and postoperative x-rays.

was 6.2 months. The shortest follow-up was one month and the longest 20 months.

Complications

The post-operative complications were analyzed. Sixteen patients had some type of complication. Four of them had two or more complications for a total of 22 complications. They are detailed in **Figure 5.** It is interesting to note that 16 of the 22 complications occurred during the first one-third (18 patients) of this total series, and only six complications occurred during the last two-thirds (54 patients) of the series. In 56 of the 72 procedures there were no complications.

Case Histories

Two case histories are included to illustrate typical cases.

D.B. is a 29 year old junior executive who first developed bilateral hip pain and disability in 1966. A diagnosis of rheumatoid spondylitis was made and he was treated with a rigid exercise program and occasional hip injections. A left hanging hip procedure was done elsewhere in 1968 but he continued a progressively more disabling course and when seen in 1969 was losing physical and employment dependence. He had severe pain, 45° flexion contractures, used two crutches and could walk only two to three blocks. His hip scores were 24 and 25. In November 1969 he had bilateral McKee-Farrar total hip replacements separated by a two week recovery period. He is now pain free, has no limp and is at full activity and there is no significant limitation of motion. His hip score is 97 bilaterally.

R.B. is a 49-year old man who sustained a femoral neck fracture in 1966. The head went on to aseptic necrosis so he had a subtrochanteric osteotomy in 1968. Because of continued pain, he had a cup arthroplasty in 1969 which dislocated postoperatively and required reduction and spica immobilization. When seen by us initially in 1970, he complained of severe pain, had a gross limp, used two crutches and could get about only indoors. His hip score was 21. On March 8, 1971, a Charnley total hip replacement was done. On most recent follow-up one year later, he was pain free and had a trace limp with nearly a full range of motion. His hip score is 90.

Since the preparation of this report, one McKee-Farrar implant has been removed because of persistant drainage. Some purulent material surrounded the prosthetic neck but the cement bone interphase was solid.

Another patient died of heart disease 10 months after her McKee-Farrar total hip replacement. Autopsy findings indicated some metal wear debris around the joint but good tissue tolerance.

Discussion

Since methyl methacrylate cement is now available for general use, total hip replacement is destined to be an extremely popular procedure. The outstanding feature of this procedure is pain relief. Some patients are so enthusiastic postoperatively that it is difficult to keep them within activity restrictions. Because pain relief can be so spectacular, there is a tendency for the surgeon to liberalize his indications. Because of the multitude of possible serious complications, this danger cannot be over-emphasized. Since some of the possible complications can be disastrous, rigid criteria for surgery must be maintained.

In addition to those listed above, other surgeons have reported several serious complications. Operative complications include hemorrhage, femoral artery perforation, iliac artery perforation, femoral nerve damage, sciatic nerve damage, fracture of the greater trochanter, fracture of the femoral shaft, perforation of the femoral shaft by the rasp, knee ligament injury, limitation of hip motion, malpositioning of the prosthetic components, hypotension and sudden death. Early post-operative complications include hematoma formation, pneumonitis, thrombophlebitis, pulmonary emboli, superficial or deep wound infections and wound dehiscence. Late post-operative complications include ectopic bone formation in the hip joint capsule, deep wound infections, loosening of the prosthesis, pseudarthrosis of the osteotomized greater trochanter and greater trochanteric bursitis. In addition to those listed above, reported deaths from medical reasons have included gastrointestinal hemorrhage, operative hemorrhage, renal failure, myocardial infarctions, bleeding secondary to anticoagulation, congestive heart failure, pulmonary embolism, cardiac arrest, cerebral vascular accidents, arrhythmias and pneumonitis.

The longevity of the total hip replacement prosthesis is not known. It should therefore be used in elderly patients unless extenuating circumstances predict a shortened life span. The age limitation can be lowered in patients with bilateral disease. The mechanical limits of the prostheses also are not known. Therefore, alternative procedures should be considered in heavy laborers. Since later removal of the prosthesis is occasionally necessary, a Girdlestone resection arthroplasty should be an acceptable salvage procedure in each patient considering total hip replacement.

Total replacement is not an automatic substitute for all other reconstructive procedures of the hip. In our clinic, osteotomy or cup arthroplasty procedures are still used in younger patients if the anatomical indications are present. Total hip replacement is a useful procedure to be added to the armamentarium of the reconstructive orthopaedic surgeon if the concepts and pitfalls for its use are thoroughly understood.

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Perinatal tips

By Paul M. Zavell, MD
Detroit

The following case from the files of the Wayne County Medical Society Perinatal Mortality Committee is presented as an aid in continuing education.

Maternal

This was the first pregnancy of a Gravida I, Para 0 (1), 26 years old, 0+ white mother. Her pregnancy was uncomplicated with no unusual illness, fever or bleeding, but she gained eight pounds total. At term she went into early active labor and after two hours, 45 minutes her membranes were ruptured artificially revealing a thick green, pea-soup colored amniotic fluid. After 5 hours, 13 minutes of total labor she delivered her 6 pound, 15 ounce son. Studies done on the mother were: VDRL = neg., urinalysis = neg., Hgb. = 13.7 gms.

Fetal

This male infant born at 12:10 A.M. had an Apgar of 4 at one minute and 8 at five minutes due to slow irregular respirations, cyanosis and poor muscle tone with a heart rate of 90-100 initially. He was put into oxygen with mist. However, grunting, shallow respirations with retraction and some paleness were noted on the nurse's notes when he came to the nursery. He was seen by a resident physician 30 minutes after birth who diagnosed "respiratory distress" but felt the infant had done well in oxygen. The oxygen with mist was changed to oxygen with ultrasonic humidification and suction prn.

At 8:40 A.M. (or at 8½ hours of age) the infant was seen by his private doctor who immediately became alarmed with the infant's condition. He passed an umbilical vein catheter and started the infant on 10% glucose water with added $NAHCO_3$ at the rate of 10 meq/100 cc solution. No studies were done at this time. One hour later the infant showed some cyanosis even in oxygen and the heart rate was noted to be 160-170/minute.

The private doctor resaw the infant and felt the respiratory distress was getting worse. He started the infant on IM Digoxin (0.06 mgm IM stat and 0.03 mgm q8h x 2), IM aqueous penicillin 100,000 units q12h and IM Kanamycin 22 mgm q12h.

A chest x-ray was done showing "pulmonary findings consistent with hyaline membrane. However, there may be a small pneumothorax space in the right cardiophrenic area." A surgical consultant saw the infant at 10 A.M. He felt this was a tension pneumothorax and inserted a tube into the right thorax. Immediately the infant showed marked improvement. A chest x-ray at 11 A.M. showed the tube in place but no other changes.

For the next 32 hours the infant's condition remained about the same. At about 7 P.M. of the second day of life the infant suddenly became cyanotic again with increasing respiratory distress and retractions. The hospital intern on pediatrics saw the infant and his impression was "worsening of the respiratory distress." He ordered a chest x-ray that was read within an hour as "pneumothorax has recurred with almost complete opacification of both lungs."

He notified the private physician who came in to see the infant at 9:30 P.M. He felt the infant's condition was worse and prepared to transfer him to NICU at another hospital. While arrangements were being made the infant suddenly choked and expired. The final diagnoses were: "Respiratory distress syndrome with pneumothorox on right." A post mortem was done that revealed bronchopneumonia bilateral of the aspiration type.

Perinatal Committee Comments

1. Green pea soup amniotic fluid could indicate intrauterine distress as well as possible infection.
2. A weight gain of only 8 pounds in pregnancy does not in itself indicate a problem. The mother's prior nutrition, weight and health, also must be considered.
3. Criticism of the private physician is made because he did not see the infant until about 8½ hours of age despite "respiratory distress" noted after birth that did not clear up immediately with suction, O_2 heat, and other treatment.
4. It is questionable that treating a slightly increased heart rate (160-170 versus normal of 120-140) without other findings as heart disease is wise or justified.

Doctor Zavell is chairman, Neo-Natal and Hospital Care Commitee, Michigan Chapter, A.A.P., and chairman, Perinatal Mortality Study Committee, Wayne County Medical Society.

Silicone granulomatous disease of the breast simulating cancer

By Donald H. Kuiper, M.D.
Lansing

Summary

A 34-year-old ex-entertainer developed a breast mass five years following silicone injections. This mass presented with physical and mammographic signs which were suggestive of breast cancer. Excision biopsy revealed the mass to be a silicone granuloma. The patient illustrates another complication of augmentation mammoplasty, namely physical and mammographic signs of breast cancer. When breast masses are found, the patient should be carefully questioned about previous injections.

Carcinoma of the breast is one of the most common tumors of women.[1]

The breast is often the object of cosmetic surgery. Cosmetic procedures do change the physical examination characteristics of the breast and the physician should bear these in mind when he examines the breasts. A number of materials have been employed to enlarge the breast size or alter their contour. Silicone,[2] fat[3] and paraffin[4] have all been used with varying degrees of success.

To date, we have been unable to find any reports which indicate a greater frequency of carcinoma in breasts which have been augmented by the addition of prosthetic substances. Harris[5] followed 16,660 patients with augmentation procedures and reported the same frequency of breast cancer as in a control population. Nevertheless, these cosmetic procedures do alter the normal physical examination of the breast and may change the appearance of subsequent mammograms.

In this paper, we would like to report the findings of a patient who received silicone injections into her breasts and five years later developed an irregular breast mass which was thought to be a carcinoma on both physical examination and mammography. Excision biopsy revealed the mass to be a silicone granuloma.

Case Report:

S.M., a 34 year old divorced white female was evaluated for symptoms of lactose intolerance on January 5, 1971. Her history revealed 10 years of intermittent loose water brown stools accompanied by excessive flatus. She denied bloody or tarry stools and the stools were never seen to float. There was no oil or grease in the stools. These episodes occurred weekly and lasted from one to five days. The symptoms would come on following the ingestion of milk, ice cream and chocolate. She denied travel outside the United States and was unaware of the ingestion of contaminated water. There was no nausea or vomiting and her appetite was good except when the diarrhea was at its peak of six to seven stools per 24 hours.

Her past history revealed an allergy to penicillin manifested by generalized hives. She had a cholecystectomy for cholelithiasis in July 1970. At age 29 a heart murmur was detected on a routine physical examination but there were no signs or symptoms of rheumatic fever earlier in life. Her alcohol ingestion was limited to one to two cocktails per month and she did not smoke. She was employed as a legal secretary. Five years prior to her present visit, she received a number of breast injections with silicone while in California working as an "entertainer." She did not recall if the injected material was "pure" silicone. On physical examination she was a well developed white female in no particular distress. Weight 173½ pounds, blood pressure 130/74, pulse 88/min. and height 5'10".The HEENT were unremarkable. The lungs were clear to percussion and auscultation. The heart was not enlarged and there were no thrills or heaves. A grade 2/6 diastolic blowing low-pitched murmur was heard over the second right intercostal space parasternally and it radiated down the left sternal border. The rhythm was regular. Examination of the breasts revealed the right breast to be free of masses, tenderness or nipple discharge. Palpation of the left breast revealed at the 2 o'clock position of the upper outer quadrant a hard moderately tender irregular mass measuring 3.0 x - 2.0 x 2.0 cm. The borders were somewhat irregular and it was not freely movable. There was a suggestion of skin retraction but no nipple discharge. The axillae and supraclavicular areas were free of

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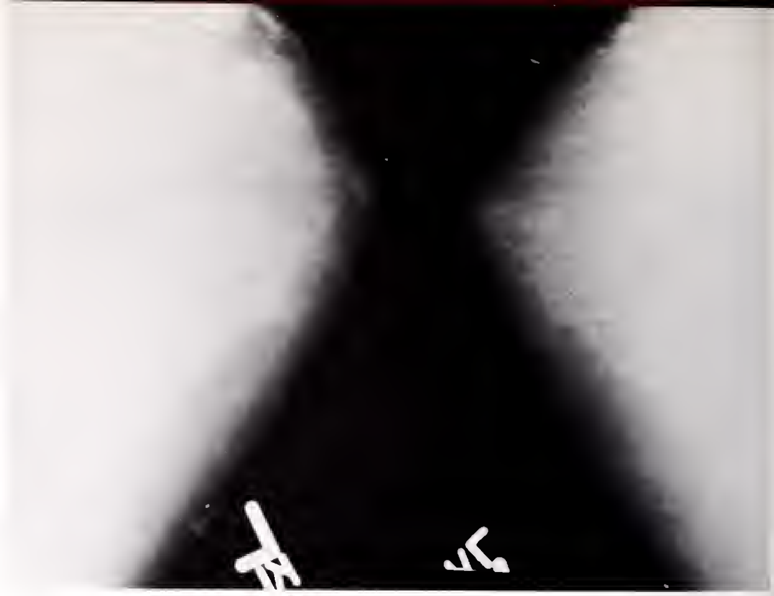

Fig. 1-A. Mammogram of left breast. Note the discrete mass in upper quadrant.

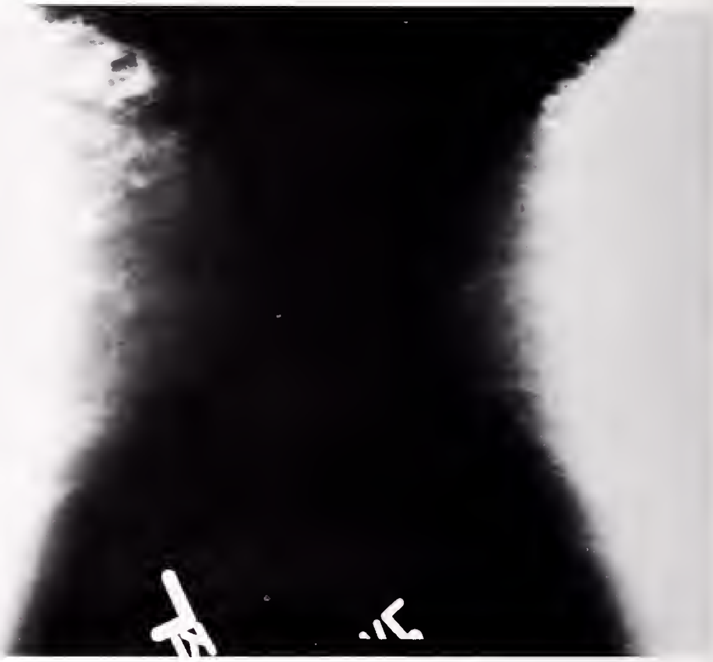

Fig. 1-B. Mammogram of left breast-penetrating view. Areas of large calcifications are seen.

masses and adenopathy. The abdomen revealed a well healed right upper quadrant oblique scar from the cholecystectomy. Palpation revealed modest tenderness over the descending colon. The remainder of the physical examination was unremarkable.

Laboratory: Hb=13.0 g%, Hct=41 vol.%, WBC=7,300 with a normal differential count. A urine analysis, chest x-ray and a multiphasic screening test-12 was normal. EKG was normal. Stools for occult blood and for ova and parasites were normal. A sigmoidoscopy was unremarkable to the 25.0 cm level and a barium examination of the colon revealed an isolated diverticulum of the sigmoid colon. A lactose tolerance test was strongly positive with a flat glucose curve and the patient experienced abdominal bloating and diarrhea within 30 minutes of the lactose challenge.

Bilateral mammograms were done. (See **Figs. 1-A and B**) The breasts were symmetrical in their development. There was no evidence of nipple or skin retraction. There was an irregular zone of increased density in the upper outer quadrant of the left breast. The margins were ragged and it measured 3.0 x 2.0 x 1.5 cm. Several large calcifications were noted. On February 11, 1971, an excision biopsy was done. Grossly, a 4.0 x 4.0 x 5.0 cm firm mass was excised. The cut sections had a glarey tan homogeneous firm surface. The microscopic sections (See **Fig. 2**) confirmed the frozen section diagnosis of a silicone granuloma. Fibrous cords with intervening spaces and foreign body giant cells with droplets in the cytoplasm were noted. No evidence of malignancy was found.

Discussion:

Our patient had undergone a complete physical examination six months prior to the present examination when the breast mass was discovered. This would suggest that the mass formed during the intervening six months. When confronted with a breast mass, one should remember to question the patient about previous cosmetic procedures on the breasts; which may include the injection of foreign materials. It was during her third visit to our office that our patient offered the history of the previous breast injections.

Silicone (dimethylpolysiloxane) is a very innocuous substance and therefore, has been frequently employed in reconstructive surgery. Pure silicone does not stimulate antibody formation and it generally behaves as an inert polymer when injected into a living organism.[6,7,8] At the present time, the injection of silicone has been banned by the Food and Drug Administration.[2] However, a number of patients still present with a history of past silicone injections. When pure silicone is injected into the breast, it has a tendency to migrate to other locations with a loss of the intended cosmetic effect and may give rise to spurious masses which only serve to confuse the physician and frighten the patient.

In order to prevent this migration, certain additives have been injected along with the silicone.[2] These substances (castor oil, mineral oil or other animal or vegetable oils) induced a scarring and fibrotic reaction in the tissues with a fixation of the silicone in situ. It was undoubtedly the collection of fibrous tissue and silicone which gave rise to our patient's mass with skin retraction.

A number of complications have been reported following augmentation mammoplasty. It is believed that the majority of them are the result of impurities which are added to the pure silicone. These complications have included infection at the injection site,[9] foreign body reaction with rejection of the injected material,[10] delayed hypersensitivity reactions with the loss of both breasts[2] and the formation of silicone granulomas.[11]

We believe that our patient illustrates another complication, namely, physical and mammographic findings of breast cancer. She developed these findings five years following the injections. We have been unable to document that materials other than silicone were injected, but we suspect that she received a combination of silicone and an oil.

There does not appear to be an increased occurrence of mammary cancer following augmentation mammoplasty. de Cholnoky[12] found only seven cases of breast cancer in over 10,000 patients with mammoplasties who were followed for 18 years.

Although the incidence of malignant tumors has not apparently increased, our patient emphasizes the issue that breast masses may develop which simulate a carcinoma. It is clear from our patient that mammography will not delineate the benign nature of the silicone granuloma, only excision biopsy will establish the diagnosis. Minagi, et al[13] described two distinct roentgen appearances of silicone on the mammogram. The most frequent appearance is that of small-to-moderate sized nodules with sharply defined margins. The other pattern is that of a homogeneous appearance with little or no tendency to form discrete nodules. These authors speculated that the variation between the two patterns may be a function of the purity of the injected fluid with the homogeneous pattern resulting from pure silicone. They, however, had no histologic confirmation of their x-ray impressions.

Egan[14] has defined four primary criteria for the mammographic diagnosis of breast cancer. 1. The lesion must show an increased density over the surrounding breast tissue, with the greatest density in the center. 2. The palpable size of the lesion is usually 2-4 times that measured on the mammogram. 3. The shape of the mass may vary with the degree of invasion into the surrounding tissue and the cellular reactive proliferation to this invasion. The infiltrative pattern represented by scirrhous carcinoma has irregular margins which may be tentacled and spiculated. The circumscribed pattern may be smooth in some areas with well defined borders. 4. The presence of typical intramammary calcifications. These most often occur in the intraductal carcinoma, but have been seen in every histologic type of carcinoma. To be of significance, the calcification should have the following criteria:

a. Very faint to dense
b. Indefinite borders
c. They should be confined to a measurable area of the breast.
d. They should be too numerous to count.
e. They should be very fine.
f. They should be scattered throughout the mass.

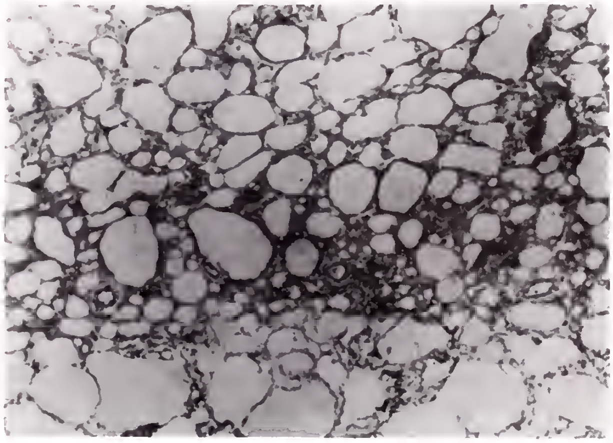

Fig. 2. Histologic section of breast mass. Note the numerous foreign body giant cells within the granuloma. No malignancy is seen. 10 x 0.25

Our patient fulfilled three of the four primary criteria of Egan. Only coarse large areas of calcifications could be seen on the mammogram. Breast masses occurring after silicone injection may give the appearance of cancer on physical examination and on mammography. Only excision biopsy with histologic examination will establish the diagnosis of granuloma formation.

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Neonatal immunology: a review of host response to infection

By Ralph C. Gordon, M.D.
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Newborn infants are somewhat unique in their tendency toward development of serious infections and this is partly related to a state of relative immune deficiency. Bacterial sepsis occurs in 1/500 to 1/1,600 live births and carries a mortality of 13-45%.[1] The incidence of neonatal bacterial meningitis in the recent collaborative study of 54,535 newborns carried out by the National Institute of Health was 0.46 cases/1,000 live births and had an associated mortality of 60%.[2] Meningitis and septicemia therefore continue to be significant causes of severe neonatal disease and death. Viral infections also are not unusual in newborns and the viruses most commonly involved are cytomegalovirus and rubella virus which can be isolated from 6-15/1,000 and 0.7/1,000 live births respectively.[3]

The basic mechanisms involved in the protection of the individual against infection are listed in **Table 1** and discussed in further detail particularly regarding neonatal aspects in the following paragraphs.

Studies of the neonatal inflammatory response have been carried out using the Rebuck skin window technique in which a small area of the skin is scarified and then a series of cover slips are applied and removed at intervals for staining and microscopic study of the cellular inflammatory response. In the normal adult there is a shift from polymorphonuclear to mononuclear cells in 8-12 hours while this is delayed in infants. Likewise the polymorphonuclear response of infants shows a significant eosinophilia and whether these cells are as active in phagocytosis as granulocytes is unknown. Some studies have also indicated that newborns cannot concentrate inflammatory cells at the site of infection as well as adults.[4]

TABLE 1
Host Defence Mechanisms

Inflammatory response
Phagocytosis
Cell-Mediated Immunity
Immunoglobulins
Complement-Mediated Immunity

Several studies of phagocytosis have been carried out and it is generally accepted that newborn serum is deficient in the capacity to opsonize or prepare organisms for phagocytosis by polymorphonuclear leucocytes.[4,5] There is less agreement in the literature regarding whether granulocyte function itself is also deficient in the newborn.[5,6]

It is appropriate at this time to mention the N.B.T. (nitroblue tetrazolium) test, a test of polymorphonuclear cell function in which blood is mixed with N.B.T. dye which is taken up by these cells.[7] In the normal adult or child 5-10% of the polymorphonuclear cells will pick up and reduce the dye to formazan which gives a black deposit in the cell enabling counting. In the normal patient the percent positive cells will increase markedly in the presence of bacterial infection but remain in the "normal" range with viral infection. This test is unreliable as an indicator of bacterial infection in the newborn since it usually shows results in the strongly positive range of approximately 38% in normal newborns and reverts to a lower value in the face of severe infection.[7] These elevated values have been attributed to increased metabolic activity of the neonatal polymorphonuclear leucocytes and this is under study at present.

The next topic is that of cell-mediated immunity. It should be made clear to the reader that this does not refer to phagocytosis by polymorphonuclear cells but pertains to the part taken by lymphocytes and macrophages in the host's defense.[6] General examples of the biologic importance of this mechanism are the tuberculin test and the rejection of skin grafts by normal people. Therefore, cell-mediated immunity has to do with delayed hypersensitivity.

Of perhaps even more importance to the present discussion is the relationship of cellular immunity to congenital viral infection since these cells are involved in the production of the antiviral protein interferon and other yet undefined mechanisms of immunity.[8] Congenital rubella is an example of probable deficient cellular immunity since there are high levels of antibody while virus may persist for months in many babies.

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TABLE 2

Normal Immunoglobulin Levels[12]
(Mg./100 Ml.)

Age	IgG	IgM	IgA
Newborn	1031±200	11±5	2±3
1-3 mos.	430±119	30±11	21±13
4-6 mos.	427±186	43±17	28±18
7-12 mos	661±219	54±23	37±18
13-24 mos.	762±209	58±23	50±24
2-3 years	892±183	61±19	71±37
3-5 years	929±228	56±18	93±27
6-8 years	923±256	65±25	124±45
9-11 years	1124±235	79±33	131±60
12-16 years	946±124	59±20	148±63
Adult	1158±305	99±27	200±61

Experimental studies of cell-mediated immunity also have demonstrated a deficiency of this mechanism in the neonate. Young infants have been shown to be inconsistent in their capacity to develop skin sensitization or delayed hypersensitivity to the chemical 2,4 dinitrofluorobenzene while older children and adults are readily sensitized to this agent. Mouse studies have indicated that newborn animals are not resistant to herpes simplex virus given intraperitoneally while older animals are resistant which is interpreted as an age-dependent cellular immune defect.[6] It is also of note that certain infections usually handled by cellular mechanism, i.e. herpes simplex, varicella, cytomegalovirus, toxoplasmosis, tuberculosis and listeriosis among others, are especially damaging to the newborn.[6]

The serum immunoglobulins are of great importance in resistance to infectious diseases particularly through their activity in opsonizing bacteria for phagocytosis, killing bacteria in the specific complement-related system and in neutralizing viruses. The blood of the newborn contains essentially IgG globulins from the mother and so will protect only against certain organisms. Some examples include the rarity of *Hemophilus influenzae* infections in the immediate neonatal period and of rubeola in the very young infant because of the usual maternal antibodies present. Indeed, rubeola vaccine is sometimes not effective if given to a child less than a year of age because of the persistence of maternal antibody.

Notably absent from the serum of a normal neonate is IgM globulin which does not cross the placenta from the mother thus resulting in a deficiency in opsonization and in a deficiency in complement-mediated killing of bacteria as exemplified by *Escherichia coli.* Although IgM does not cross the placenta it may be found in the sera of infants with congenital infections because its production is the primary humoral response to infection of a fetus or newborn. The intrauterine and postnatal development of serum immunoglobulins has been extensively studied by Alford[9] who has established the importance of an elevated IgM (20 mg.% or greater) in alerting the physician to the possibility of a congenital infection. On the other hand it has also been demonstrated that a low IgM level does not rule out congenital infection by any means. Normal ranges of serum immunoglobulins at various ages are shown in **Table 2** as adapted from the literature.[12]

The final aspect of the normal immune response to be considered is that of the complement-mediated immune system which is a complicated system of nine serum proteins which interact in a way somewhat reminiscent of the blood clotting factors.[6] Complement activity is involved in increased vascular permeability and migration of polymorphonuclear leucocytes, enhanced phagocytosis and in killing of bacteria by cell lysis as shown in **figure 1.** Total complement activity has been found to be deficient in newborns with levels approximately 1/2 those of maternal sera.[10]

Newborn infants have a deficiency in almost all of the normal immune mechanisms. This does not mean that they are null or incapable of reacting to infections since in reality they do have relatively good responses to many infections. The specific immune responses may also be of great diagnostic help to the physician. As an example we can summarize the serologic happenings in congenital cytomegalovirus infection where study of the cord blood will reveal the presence of both maternal IgG antibody against the virus as well as IgM antiviral antibody from the infant. On observation the IgG antibody will fall sharply by three months of age while the IgM remains elevated. This phenomenon has led to the development of specific serological tests for congenital infection using fluorescent antibodies directed against the IgM produced by the host in response to congenital infection.[11] By these techniques it is possible to determine the organism causing the congenital infection.

Since no material administered to a newborn, including commercial gamma globulin,[12] will improve the functioning of the infant's immune defense system, it is incumbent upon the physician to protect the newborn from exposure to noxious organisms in the environment and to be alert for the rapid diagnosis and treatment of infections when they develop.

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Figure 1
Components of Human Complement
(In Sequence of Action)

C1 C4 C2 C3 C5 C6 C7 C8 C9

/——/

Virus Neutralization

/————————/

Opsonization

/——————————/

Increased Vascular Permeability

/————————————————/

Attraction of Polymorphonuclears

/——————————————————————/

Cell Lysis and Death

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

MONTHLY SURVEILLANCE REPORT

CASES OF CERTAIN DISEASES
REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH

For the five-week period ending Feb. 1, 1973

	1973 This 5-Week Period	1972 Same 5-Week Period	1973 Total To Above Date	1972 Total Same Date	Total Cases for 1972
Rubella	91	126	91	126	1,460
Congenital Rubella Syndrome	0	0	0	0	1
Measles	230	218	230	218	2,353
Whooping Cough	12	16	12	16	116
Diphtheria	0	0	0	0	1
Mumps	770	419	770	419	3,729
Scarlet Fever & Strep Sore Throat	2,458	1,317	2,458	1,317	13,304
Tetanus	0	0	0	0	2
Poliomyelitis (paralytic)	0	0	0	0	0
Hepatitis	385	511	385	511	4,322
Salmonellosis (other than S typhi)	51	76	51	76	781
Typhoid Fever (S typhi)	1	0	1	0	7
Shigellosis	72	62	72	62	574
Aseptic Meningitis	16	6	16	6	266
Encephalitis	11	8	11	8	108
Meningococcic Meningitis	1	6	1	6	55
H Influenza Meningitis	7	6	7	6	81
Tuberculosis	78	112	78	112	1,609
Syphilis	364	459	364	459	4,815
Gonorrhea	2,763	1,980	2,763	1,980	24,728

Information can be supplied by the local health department on the local incidence of disease

Maurice Reizen, MD, Director
Michigan Department of Public Health

Michigan mediscene

March 14-17 — 10th International Conference, the Association for Children with Learning Disabilities, Cobo Hall, Detroit, contact: Albert Katzman, chairman, 19991 Cherry Hill, Southfield.

March 16-17 — 25th anniversary symposium, "Epilepsy '73," sponsored by Epilepsy Center of Michigan, Wayne County Medical Society headquarters, contact: Miss Cheek, Epilepsy Center of Michigan, 10 Peterboro, Detroit, 48201.

March 20 — Annual Legislative Day, Woman's Auxiliary to MSMS, Olds Plaza Hotel, Lansing, contact: Mrs. R.J. Westerhoff, 2458 Maplewood, SE, Grand Rapids, 49506.

March 21 — The Council, MSMS headquarters, contact: Warren Tryloff, director.

March 21-22 — Annual Michigan Conference on Maternal and Perinatal Health, Olds Plaza Hotel, Lansing, contact: Helen Schulte, MSMS headquarters.

March 25 — Midwinter seminar, Michigan branch, American Association of Medical Assistants, noon, E. Lansing, contact: Margaret Broadwell, 406 Professional Plaza, 3800 Woodward Ave., Detroit, 48201.

March 28 — Council of Specialty Societies, 2 p.m., MSMS headquarters, contact: Glenn E. Moore, MD, chairman, 323 W. Second, Flint, 48503.

April 3 — Spring meeting, Michigan TB and Respiratory Disease Association, Michigan Thoracic Society, at University of Michigan, contact: Les Harcus, MTBRDA, 403 Seymour, Lansing, 48914.

April 5 — Eighth annual conference of Medical Aspects of High School Sports, Kellogg Center, East Lansing, contact: James Feurig, MD, medical director, Olin Health Center, Michigan State University, East Lansing, 48823

April 5-6 — 24th Annual Heart Days, Michigan Heart Association, Civic Center, Lansing, contact: MHA, P.O. Box L-V 160, Southfield, 48076.

April 13-15 — Seminar, "Ethical Questions in the Biological Revolution, for Physicians and Clergymen," Institute for Advanced Pastoral Studies, Bloomfield, contact: James A. Read, MD, 610 N. Woodward, Birmingham, 48011.

April 25 — Allied Health Arthritis Seminar, Michigan Chapter, Arthritis and Rheumatism Foundation, Sparrow Hospital, Lansing, contact: Michigan Chapter, ARF, 27308 Southfield, Lathrup Village.

April 25 — Physicians for Michigan Communities Day, sponsored by Michigan Health Council, at Scott Hall, Wayne State University School of Medicine, contact: John A. Doherty, executive vice president, MHA, 712 Abbott, East Lansing, 48823.

April 26-29 — Annual State Convention, Michigan branch, AAMA, Dearborn Inn, Dearborn, contact: Margaret Broadwell, 406 Professional Plaza, 3800 Woodward Ave., Detroit, 48201.

May 4-5 — Sixth annual cancer symposium, "Management of Advanced Breast Carcinoma," sponsored by Wayne State University School of Medicine, American Cancer Society, Michigan Division, and Michigan Cancer Foundation, Wayne County Medical Society headquarters, $25 fee, contact: Mrs. Dorothy Bewley, symposium registrar, 4160 John R Street, Detroit, 48201.

May 9 — 105th Annual Clinic Day and Reunion Banquet, WSU School of Medicine Alumni Association, Detroit Hilton Hotel, contact: Donald Burkholder, University Relations, School of Medicine, Wayne State University, Detroit, 48201.

May 9 — Seminar, "Diseases of the Reticuloendothelial System," Michigan Society of Pathologists, Scott Hall, Wayne State University School of Medicine, contact: Jacob E. Briski, MD, Saint John Hospital, 22101 Moross Road, Detroit, 48236.

May 9-12 — Seminar, "Life-Saving Measures for the Critically Injured," sponsored by American College of Surgeons' Committee on Trauma, Wayne State University, contact: Alexander J. Walt, MD, chairman, Department of Surgery, WSU School of Medicine, 540 E. Canfield, Detroit, MI 48207.

May 10-11 — Sixteenth Annual Clinic Days, Children's Hospital of Michigan, Detroit Medical Center, contact: Edward W. Green, MD, Children's Hospital, 3901 Beaubien Blvd., Detroit, 48201.

May 13-15 — Second Annual Spring Meeting, MSMS House of Delegates, Boyne Mountain Lodge, Boyne Falls, contact: Richard Campau, MSMS headquarters.

May 15-16 — Spring Conference, Woman's Auxiliary to MSMS, Hidden Valley Lodge, Gaylord, contact: Mrs. Fleming Barbour, 2015 Lincoln Drive, Flint, 48503.

May 16-18 — Annual meeting, Michigan Public Health Association, Olds Plaza Hotel, Lansing, contact: Mrs. Anna Langela, executive secretary, MPHA, 403 Seymour, Lansing, 48914.

May 23 — Council of Specialty Societies, 2 p.m., MSMS headquarters, contact: Glenn E. Moore, MD, president, 323 W. Second, Flint, 48503.

May 24 — Michigan Conference on Rural Health, sponsored by MSMS, Michigan Health Council, MSU, Kellogg Center, East Lansing, contact John A. Doherty, executive vice president, MHC, 712 Abbott, East Lansing, 48823.

Oct. 7-11 — 108th MSMS Annual Session, Sheraton-Cadillac Hotel, contact: Helen Schulte, for Scientific Sessions information, and Richard Campau, for House of Delegates information, both at MSMS headquarters.

Non-allergic adverse reactions to aqueous procaine penicillin G

By Thomas F. Downham, II, MD
Daisy P. Ramos, MD
Detroit

The authors make the following comments about their paper:

At the Detroit Social Hygiene Clinic in Herman Kiefer Hospital, interest was aroused from a reprinted paper (United States Public Health Service) entitled "Acute Psychotic Reactions to Aqueous Procaine Penicillin." During a two year period it became more apparent that this type of reaction was being seen with increased frequency in our clinic. A review of the recent literature also was done, however, few case reports were noted in the American literature, nor was there an adequate explanation as to the possible cause of this unusual reaction.

We feel that the paper is significant because it **compares** *a non-allergic reaction (pseudoanaphylaxis) to an allergic reaction (anaphylaxis) which may be clinically difficult to differentiate. We hope that other physicians find the article helpful, especially for treatment of these* **potentially** *life-threatening reactions.*

Upon completion of this report, we became aware of a recent article (Letters to the Editor — **Archives of Dermatology,** *Vol. 106, No. 4, October, 1972) suggesting that this "psychotic" reaction* **only** *occurred in black males. However, we have seen recently an additional pseudoanaphylactic reaction in a white male and our report also indicates that it can occur in black females (2 cases). The scheme of the possible pathophysiology of pseudoanaphylaxis may generate interest in this unusual reaction so that further investigation may be done.*

Penicillin, the "wonder drug" of the twentieth century, is used ubiquitously for treatment of a variety of infectious diseases. It is available in various pharmacological combinations for different routes of administration. The single most deleterious adverse reaction to penicillin, either alone or in combination with another drug, eg. aqueous procaine penicillin G (APPG), is the anaphylactic type reaction which claims approximately 80 lives per year in the United States.[1] Recently, in the American literature there have been reported 10 cases of acute psychotic reactions or pseudoanaphylactic reactions immediately following intramuscular injections of APPG. European literature has cited 73 cases of this unusual reaction which must be differentiated from an allergic anaphylactic reaction. Utley, *et al* have summarized these 83 cases.[2]

We wish to report 14 additional cases of non-allergic adverse reactions to APPG during an 18 month period at the Detroit Social Hygiene Clinic. Significant clinical differences between anaphylaxis and pseudoanaphylaxis will be emphasized along with treatment. The possible pathophysiologic mechanism of pseudoanaphylaxis will be discussed.

Case Reports

Table I summarizes the clinical data on 14 cases of pseudoanaphylactic reactions to APPG from 1-10-71 to 7-2-72. Incidence of the pseudoanaphylactic reactions was 13/10,479 or approximately one per 1,000 treatments (0.1%) given for gonorrhea.

All of our patients had a negative history for penicillin allergy. Sex ratio was 6:1, male to female. Only five of 14 cases had previous intramuscular injections of APPG yielding no untoward adverse reactions. The majority of the cases were diagnosed as gonorrhea. Case #8 (secondary syphilis) was retreated with no untoward reaction to APPG. Concomitantly, Benemid (Probenecid), along with intramuscular APPG, was administered to 8/14 patients.

Most of our cases experienced auditory symptoms, a fear of impending death, grand mal seizures and/or a violent behavioral reaction. Cases #1 and #13 had mild restlessness. Blood pressures ranged from 100-185/80-100, and pulse rates ranged from 100 to 150 per minute.

Treatment of the signs and symptoms consisted of phenobarbital two grains intramuscularly which yielded improvement in every case. Case #11 received epinephrine plus nasal oxygen mainly because of the presence of cyanosis. Benadryl, which has a sedative effect, was used in case #14.

The authors are with the Detroit Social Hygiene Clinic, Herman Keifer Hospital and the Departments of Dermatology at Detroit General Hospital and Wayne State University School of Medicine. Their paper is supported in part by the Detroit General Hospital Research Corporation.

Table 1. Summary of pseudoanaphylactic reactions at the Detroit Social Hygiene Clinic during an 18 month period.

Case	Diagnosis	PCN Allergy	Previous Treatment with APPG	Oral and IM Medications	Symptoms	Pre-Treatment Vital Signs	Treatment	Improvement	Post Treatment APPG
1. 26 y/o N/F	G	No	No	Benemid—1 Gm. APPG—4.8 mega U	Dizzy—Restless	185/85 PR-Strong	2 gr. PB-IM	Yes	None
2. 18 y/o N/M	G	No	Yes	APPG—2.4 mega U	Fell Down	100/80 PR-125/min.	2 gr. PB-IM	Yes	None
3. 17 y/o N/M	G	No	No	APPG—2.4 mega U	Tinnitus Fear of Impending Death—Restraints Required	140/96 PR-Strong	2 gr. PB-IM	Yes	None
4. 34 y/o N/M	G	No	Yes	APPG—2.4 mega U	Violent Behavioral Reaction—Fearful, Apprehensive—Restraints Required	132/94	2 gr. PB-IM	Yes	None
5. 21 y/o N/M	G	No	No	APPG—2.4 mega U	Grand Mal Seizure	140-160/? PR-Strong	2 gr. PB-IM	Yes	None
6. 23 y/o N/M	G	No	Yes	Benemid—1 Gm. APPG—2.4 mega U	Violent Behavioral Reaction—Hitting Head	140/90 PR-120/min.	2 gr. PB-IM	Yes	None
7. 21 y/o N/M	G	No	No	Benemid—1 Gm. APPG—2.4 mega U	Tinnitus Felt Weak	150/100 PR-tachycardia	2 gr. PB-IM	Yes	None
8. 28 y/o N/M	SS	No	No	APPG—2.4 mega U	Dizzy—Screaming about Dying	140/90 PR-Regular	2 gr. PB-IM	Yes	Yes
9. 17 y/o N/M	G	No	No	Benemid—1 Gm. APPG—2.4 mega U	Grand Mal Seizure	130/90 PR-tachycardia	2 gr. PB-IM	Yes	None
10. 22 y/o N/M	G	No	No	Benemid—1 Gm. APPG—2.4 mega U	Tinnitus Blurring of Vision Grand Mal Seizure	160/90 PR-120/min.	2 gr. PB-IM	Yes	None
11. 20 y/o N/M	G	No	Yes	Benemid—1 Gm. APPG—2.4 mega U	Cyanosis Grand Mal Seizure	130-60 80-90 PR-Regular	2 gr. PB-IM Epinephrine 1:1000—0.3 cc S.C. Nasal Oxygen	Yes	None
12. 18 y/o N/F	G	No	Yes	APPG—2.4 mega U	Fainted to Semi-consciousness	130/80	2 gr. PB-IM	Yes	None
13. 22 y/o N/F	G	No	No	Benemid—1 Gm. APPG—4.8 mega U	Buzzing in Ears Restlessness	180/90 PR-Regular	2 gr. PB-IM	Yes	None
14. 36 y/o N/M	G	No	No	Benemid—1 Gm. APPG—2.4 mega U	Ringing in Ears Confused, Thinking of Going to Die	150/100 PR-88/min.	Benadryl 50 mg.—IV	Yes	None

KEY: y/o=year old; N/M=Negro Male:
N/F=Negro female; G=gonorrhea;
SS=secondary syphilis; APPG=Aqueous Procaine Penicillin;
IM=Intramuscular; U=Units;
PR=pulse rate; PB=phenobarbital.

Discussion

All of our patients had a similar pattern of reaction directly in relation to the intramuscular injection of APPG. At lease one of the symptoms and one of the physical findings were present as summarized in **Table 2.** This corresponds well with Tompsett's summary of symptoms.[3] In addition, we have added violent behavioral reactions, restlessness, faintness and grand mal seizures.

The psychotic disturbances attributed to penicillin appear to fall into two distinct categories. The first category is the "toxic-allergic" group which includes patients whose psychotic manifestations are clearly associated with obvious allergic phenomena. Restlessness, confusion, and disorientation are found associated with varying degrees of allergic signs and symptoms (urticaria, edema, wheezing). The phychotic features of these patients are probably due to edematous brain lesions. Appropriate antihistaminic therapy is the treatment of choice.[4]

The second category and the group in which our cases belong is characterized by the immediate onset of an acute psychotic reaction following deep intramuscular injection of APPG **(Table 2).** Disturbances of the circulatory system are notably absent **(Table 2).** Affected patients show none of

Table 2: Comparison of Anaphylactic and Pseudoanaphylactic Reactions

	ANAPHYLAXIS	PSEUDOANAPHYLAXIS
Symptoms	Apprehension Paresthesias Choking Sensation Cough	Fear of Death Auditory Disturbances (ringing, buzzing, noises, etc.) Visual Distrubances (lights, blurring, hallucinations, diplopia Dizziness Violent Behavioral Reactions Restlessness Confusion, Disorientation Faintness Tachycardia, Palpitations Disturbance in Taste
Physical Findings	⇩ Blood Pressure ⇧ Pulse Rate Dilation of Pupils Shock Urticaria Edema Cyanosis Wheezing Loss of Consciousness Convulsions Death	⇧ Blood Pressure ⇧ Pulse Rate ± Cyanosis ± Convulsions
TREATMENT	Airway - Breathing - Circulation Principles of Emergency Care Epinephrine Antihistamines ± Oxygen ± Hydrocortisone ± Aminophylline ± IV Fluids with Levophed	Phenobarbital - 2 gr. - IM ± Oxygen ± Restraints
PROGNOSIS	Poor to Good	Good
CAUSE OF REACTION	Immediate (Humoral) Hypersensitivity to Penicillin	Inadvertent Intravenous Administration of APPG a. ? Micro-Emboli b. ? ⇩ Hydrolysis (Breakdown) of Procaine Portion of APPG Yielding a Short-Lived Chemical Toxic Reaction in Cerebral Tissue

the usual allergic symptoms associated with penicillin **(Table 2)**. Therefore, recognition of this pattern of reaction is important to avoid confusion with the much more serious anaphylactic reaction. **Table 2** summarizes the main differences between the anaphylactic and pseudoanaphylactic pattern of reaction. Since patients with the pseudoanaphylactic reaction had an elevated blood pressure and increased pulse rate there was no indication to treat them as an anaphylactic reaction. Anaphylaxis and the pseudoanaphylactic reaction could conceivably occur simultaneously and independently **(Fig. 1)**.[5]

The total incidence of the reactions was 0.1% or 1 per 1000 injections. Utley and Batchelor had incidences of 0.3%.[2,6]

Fig. 1 outlines the possible pathophysiology of a pseudoanaphylactic reaction. The timing of the reaction, the frequent presence of central nervous system symptoms, the absence of circulatory collapse and the fact that drug administration need not be interrupted suggest that it is not an allergic reaction. The occurrence of the reaction immediately after the injection is compatible with the hypothesis that the reaction is related to the inadvertent intravenous administration of the drug. It is known that there is a direct connection between the pelvic and vertebral veins and hence potentially with the cerebral circulation.[6] Disturbance of taste in the mouth also strongly suggests that some of the drug could have been accidentally injected intravenously.[6]

The accidental intravenous injection of relatively insoluble crystals of APPG might lead to microembolism. The particles of APPG usually measure 5-100μ in diameter.[2,6] However, the possibility that microembolism is a cause of the pseudoanaphylactic reaction seems lessened since no reported cases showed symptoms of pulmonary embolism.

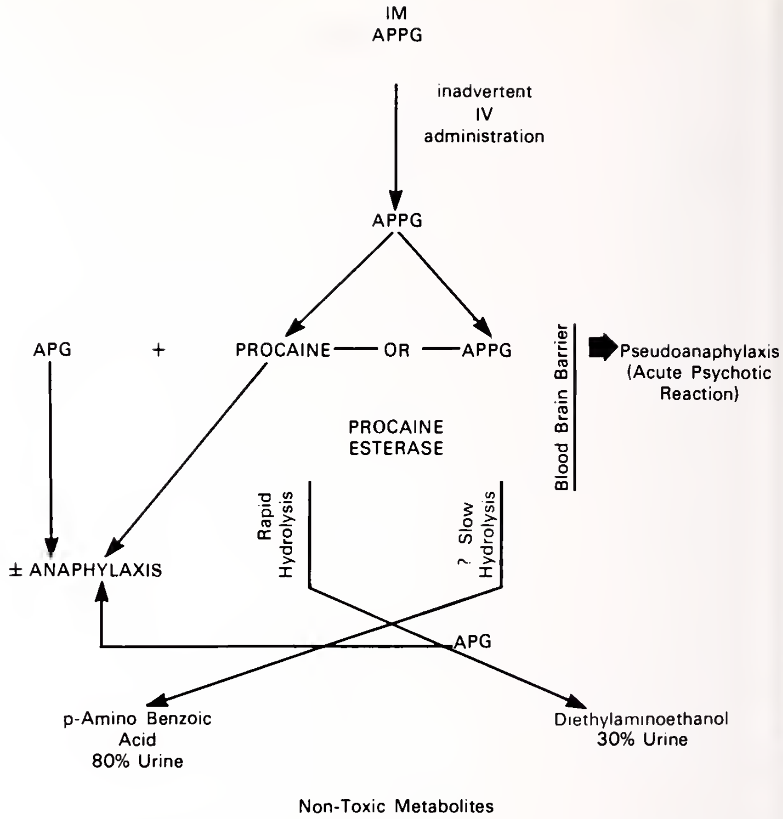

Fig. I: The Possible Pathophysiology of Pseudoanaphylaxis

Though a high concentration of penicillin in the brain is unlikely to produce symptoms, a high local concentration of free procaine might do so since observations indicate that the basic local anesthetics penetrate living cells and in most cases entirely in the form of undissociated molecules.[7] The majority of our patients received 2.4 megaunits of APPG **(Table 1)** or 960 mg. of procaine per intramuscular injection.[8] According to the law of mass action for basic anesthetics in relation to the average pH of human plasma and cerebral spinal fluid, only 6.5% or approximately 60 mg. of free procaine is present per 2.4 megaunits of APPG. This amount of free procaine may be enough to yield a high local concentration to produce the observed central nervous system symptoms.

Procaine is hydrolyzed very rapidly by procaine esterase in human plasma to the non-toxic metabolites p-aminobenzoic acid and diethylaminoethanol which are excreted in the urine, **(Fig. 1)**.[9] Foldes and Aven have shown that small amounts of procaine esterase might be present in spinal fluid.[10] They also concluded that procaine and procaine derivatives were hydrolyzed much more slowly in spinal fluid as compared to human plasma. The non-toxic metabolites may also have an additional protective function.[11] Thus, from the foregoing it is reasonable to assume that the pseudoanaphylactic reaction arises as a result of an initially high cerebral tissue concentration of free procaine followed by slow hydrolysis (break down) which yields a short-lived chemical toxic reaction in cerebral tissue.

Clinically the symptoms of a pseudoanaphylactic reaction closely parallel the systemic toxic reactions to local anesthetic drugs described by Moore and Bridenbough.[12] The early signs and symptoms are due to cortical stimulation. These announce the existence of the initial phase of a systemic toxic reaction, a warning that the reaction may progress to convulsions because of excessive stimulation of the cortex by the local anesthetic drug and subsequent hypoxia. Buff has described reactions to procaine; the most pronounced feature was tachycardia (up to 180 per minute).[6] Approximately 35% of our cases exhibited tachycardia. Utley, *et al* found that patients who received phenobarbital (120 mg.) had a more rapid recovery.[2] All of our patients (except case #14) received immediately two grains of phenobarbital **(Table 1)** with subsequent improvement. Recently, however, oxygen has been shown to be an important antidote for treatment of systemic toxic reactions from local anesthetics.[12] Although disturbance of the circulatory system is notably absent in pseudoanaphylactic reactions cyanosis has been reported to occur.[6] Of our 14 cases only one **(Table 1)** required administration of oxygen. In addition, temporary physical restraint is indicated to prevent accidental self-injury during the acute episode, especially if a violent behavioral reaction occurs.

Pseudoanaphylactic reactions are a sequel to inadvertent intravenous injection of APPG and every precaution should be taken to assure that this accident does not happen. Whatever the site of injection, special care should be taken to ensure that a vein has not been entered, and, in particular, the plunger should be withdrawn to ascertain that no blood has entered the syringe. Manipulation of the needle after the start of the injection should be avoided, and a new puncture made if necessary.

Summary

Pseudoanaphylactic reactions secondary to intramuscular administration of APPG are described. Incidence was 0.1%.

Features of the reaction as compared to anaphylaxis are discussed. The reaction is not allergic and seems to be a sequel to inadvertent intravenous administration of the drug. Tentative explanations are presented.

Measures for the treatment and prevention of the reaction are discussed.

References

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MSMS action

'P. S. Please send your picture'

Miss Jessica Trumbull of Lansing, just nine years old, wrote MSMS headquarters recently to ask some of the most profound questions about the reasons for the state society's existence. Hers were the same questions that MSMS leaders and staff members currently are wrestling with.

To carry out a "forth" grade project, she wrote, "Dear sir, For what purpose was this group formed? What does the group do? How does a person become a member of the group? P.S. Please send your picture, too."

Her letter was an example of the fascinating variety of queries that are made by mail, telephone and in person to the MSMS staff by people of all walks of life, all ages, male and female, local and out-of-state.

Following are some of the more unusual.

A young man serving a life sentence at the Michigan Reformatory in Ionia wrote in March asking about medical careers. He has been incarcerated eight years, having spent four of them employed in the reformatory hospital and two of them as head nurse. He is interested in obtaining an MD degree with a specialty in internal medicine, as he will be eligible for parole in a few years.

"Please mail me two cards of the 'soft cell' message — 'Thank you for not smoking,' " read a postcard mailed to MSMS recently from a resident of Rock, Mich.

"Please be kind enough to send me a copy of the (AMA) publication, 'If America Dies, Where Is It?' " said another short communication from a Kalamazoo woman. Actually, the publication is entitled "If America Dies, Where Will We Bury It?' " Its subject is solid waste pollution of the earth.

The amusing and unusual queries also come by telephone.

"Do radiologists really make $200,000 a year?" asked one indignant caller. Another interested party wanted to know if any Michigan schools train midwives.

Then there was the East Lansing woman who wanted to know if Finland had a national health care program that would provide for her son if he became ill while a visitor there. And the caller who said she was a medical student's wife and wanted to know the amount of the loan received by her husband and whether or not she had co-signed for it.

A local woman, hospitalized in Room 224, Lansing General, called from bedside to ask if diabetic cookbooks are published and where she might buy one.

Acupuncture and acupuncturists are frequently the subjects of telephone calls and letters, as the public seeks to learn the medical society's opinion, and, more frequently, where acupuncture is legal, and where an acupuncturist can be found.

Another common query comes from parents who want literature they can use to keep their growing children from smoking and drugs.

Other requests have been received for films on child abuse, the address of a Breast Diagnostic Institute in New York City, a world report on death statistics, the origin of a MDCM degree, the number of women physicians in Michigan and "how much money I can expect to make if I become a physician's assistant?"

One day a Lansing-area gentleman walked into MSMS offices looking for the name of a reputable family health guide so that he could surprise his wife with one on her birthday.

But, once again, it was a little Lansing girl, this time 12, who warmed the hearts of staff members, then left them laughing, when she wrote:

"Would you please send me two copies of information for being a good doctor. How I could take care of people and make them feel better and make them think they're at home. I don't like to see people hurt because it makes me feel hurt. I am thinking of becoming a good doctor and staying a doctor all of my life. When I retire I might take up something else."

1973 Annual Session to inaugurate program changes

Future MSMS Scientific Sessions, including this year's, will follow a new organization recommended by former coordinators Richard Judge, MD, and Robert L. Tupper, MD, and approved by the MSMS Council.

Doctor Judge and Doctor Tupper, who planned and organized the 1972 Scientific Sessions, urged that the 1973 sessions eliminate all general sesions and postgraduate courses. They suggested that the entire session consist of programs planned by the MSMS sections and specialty societies.

MSMS workshop informs county leaders

Kent County Medical Society, which has monthly luncheon meetings with area legislators was represented at the workshop by its Legislative Chairman Perry W. Greene, Jr., MD. Other speakers described the MSMS and AMA legislative programs and the MSMS Doctor of the Week project.

Three Michigan physicians who are interested in developing an Upper Peninsula-wide medical legislative program traveled from the western U.P. to attend the Workshop for Legislative Chairmen in mid-January at MSMS headquarters. Flanking Thomas R. Berglund, MD, second from left, chairman, MSMS Legal Affairs Committee, they are, from left, W. H. Huron, MD, and R. D. Cecconi, MD, both of Iron Mountain, and H. J. Barsch, MD, Marquette.

Judicial Commission sets policy on non-member grievances

The MSMS Judicial Commission has adopted an official policy to follow in mediating grievances against Michigan physicians who are not members.

Recognizing it does not have jurisdiction over non-members, but accepting its responsibility to those doctors and the public, the Judicial Commission will mediate grievances and matters of ethics and professional conduct, providing the non-member agrees to accept the state society's services and abide by its rules.

MSMS, under the commission's ruling, also reserves the right to disclose information to the State Board of Registration in Medicine and may forward the complaint to the State Board if the non-member does not agree to these conditions.

The MSMS House of Delegates in October, 1972, approved a resolution that the Judicial Commission establish an equitable means of handling complaints by lay persons against doctors who are not members of MSMS.

In non-member cases, the Judicial Commission plans to use, where applicable, the grievance and appeal procedures set forth in its Official Procedures of April 14, 1971, emphasizing original jurisdiction of component societies.

Attention: UEAC members

MSMS members who have joined the United European American Club are asked to contact the Mojave Management Corporation of Detroit to obtain a special sticker to attach to their UEAC membership card. The sticker entitles the bearer to a discount with the Hertz rent-a-car service, is good only in the U.S. and only when cash is paid. The address of the Mojave corporation is 2211 E. Jefferson Ave., Suite 640, Detroit, 48207.

Michigan Medicine the springboard for many articles

Each month, *Michigan Medicine* is mailed to 8,000 Michigan doctors of medicine, exchanged with 50 other publications of medical-related organizations in the U.S. and abroad, and distributed on a complimentary basis to 325 interested persons in Michigan and other states.

Many persons included in that wide circulation have a deep interest in specific articles printed in the journal. Here are samples of some of the recent requests received at MSMS headquarters for reprints or further use of the articles:

William A. Brown, Jr., Baltimore, asked permission to use "The source of health care problems of the urban poor" in a forthcoming book. By MSMS staff members John Anthony and Donna Allen, the article appeared in the July, 1972 *Michigan Medicine.* The prospective title of Mr. Brown's book is "Selected readings in contemporary health problems for college students."

John Halick, MD, Greenville, who himself authored a *Michigan Medicine* article, wrote for 12 copies of "Perspectives on psychiatric aftercare in the community," by Edward A. Nol, MD, Southfield, which appeared in the December, 1972 issue.

Richard C. Schneider, MD, Ann Arbor, who is preparing a book on football injuries, asked permission to include two *Michigan Medicine* articles. One is his own, "Cervical spine and spinal cord injuries," from the November, 1964 issue. The other is "Psychological factors in athletic injuries," by Robert A. Moore, MD, Ann Arbor. It appeared in the December, 1960 issue.

From Port Washington, N.Y.; Rockville, MD.; Beloit, Wis.; Jefferson City, Mo.; and Boston, Mass., came five more requests to reprint materials first published in *Michigan Medicine.*

Resident and Staff Physician, a Port Washington publication, wished to reprint the article, "Duties of a Medical Examiner," by J. H. Ahronheim, MD, Jackson, which appeared in the August, 1972 issue.

The Tracor/Jitco corporation of Rockville asked for blanket permission to reprint any articles published in *Michigan Medicine* which are of interest to them. Following MSMS policy, permission was granted, provided that Tracor/Jitco also obtained the permission of the authors.

The Student Association for the Study of Hallucinogens, Inc., of Beloit liked the article, "Non-medical use of Nitrous oxide: A preliminary report," which appeared in the March, 1971 issue. The association asked to reprint the article, written by Edward J. Lynn, MD, East Lansing, et. al., in its publication, *Grassroots.* A cooperative binder service, *Grassroots* serves 1,500 drug information groups, counselors and libraries. It is co-sponsored by the National Coordinating Council on Drug Education.

The Boston Alcohol Safety Action Project asked for a reprint of the article, "The role of alcohol in fatal traffic accidents and measures needed to solve the problem," by H. E. Campbell, which appeared in the October, 1964 issue.

And the Health Care Foundation of Missouri asked for a reprint of "The role of the nonphysician in utilization review," by G. Taaffe, and C. Josephson, from the December, 1968 *Michigan Medicine.* They also asked for a copy of its companion article, "The role of the physician in utilization review," by R. A. Wahl, MD, from the April, 1969 issue.

MSMS members remind schools of weight loss dangers

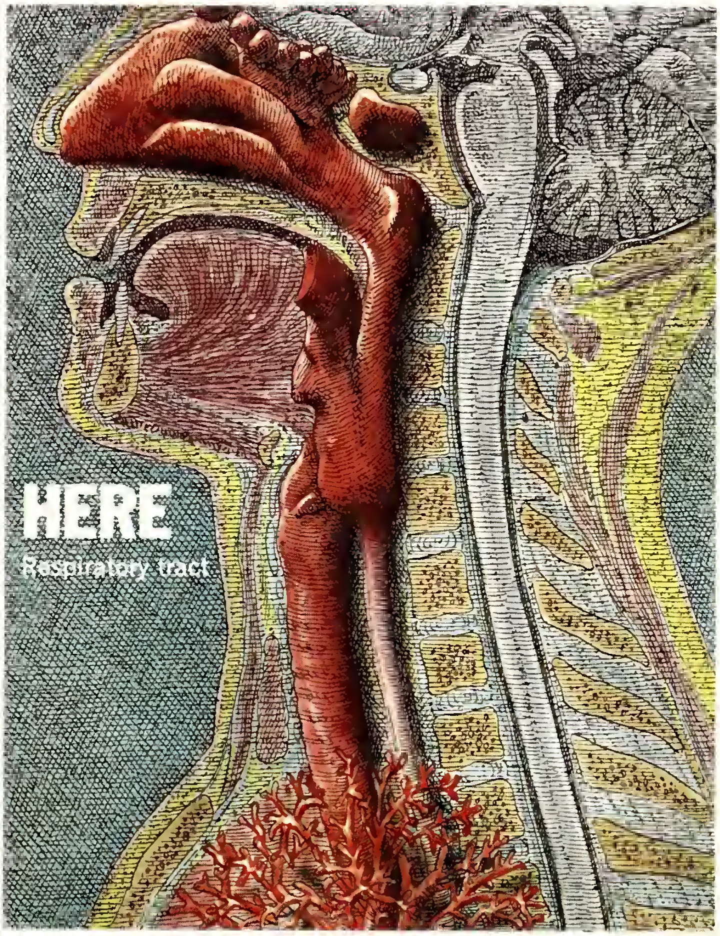
The MSMS Committee on Child Health and Welfare is seeking the aid of Michigan physicians in reminding school officials of the dangers of rapid weight loss for athletic competition.

The committee has sent its statement on wrestling weights to the Michigan Department of Education. It asked the department's aid in reminding school administrators, coaches and teachers of the health hazard to children resulting from crash diets designed to produce a rapid and extreme weight loss for athletic competition in a lower weight class.

"The committee advises," says Chairman John M. Dorsey, Jr., MD, Detroit, "that inasmuch as the problem of wrestling weights varies according to the student, no definite standards of weight be set up and that the integrity of the coach be considered as paramount in making the decision as to the best wrestling weight for each child.

"In addition, the committee recommends that physicians be available to serve as advisors to coaches on the matter of wrestling weights when this service is requested."

WHEN FLU HITS AND HURTS



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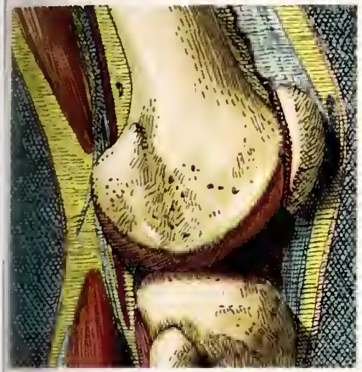
HERE Muscles and joints



Wherever it hurts, Empirin Compound with Codeine usually provides the symptomatic relief needed.

HERE Headache

n flu and associated respiratory nfection, Empirin Compound with Codeine provides an antitussive bonus in addition to relief of pain and bodily discomfort.

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Empirin Compound with Codeine **No. 3,** codeine phosphate* 32.4 mg. (gr. ½); **No. 4,** codeine phosphate* 64.8 mg. (gr. 1) *Warning—may be habit-forming. Each tablet also contains: aspirin gr. 3½, phenacetin gr. 2½, caffeine gr. ½.

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IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenc
late HCl is theoretically possible at high dosage.
not exceed recommended dosages. Administer v
caution to patients receiving addicting drugs
known to be addiction prone or having a history
drug abuse. The subtherapeutic amount of atrop
is added to discourage deliberate overdosa
strictly observe contraindications, warnings and p
cautions for atropine; use with caution in child
since signs of atropinism may occur even with
recommended dosage.

Adverse reactions: Atropine effects include dryn
of skin and mucous membranes, flushing and
nary retention. Other side effects with Lomotil
clude nausea, sedation, vomiting, swelling of
gums, abdominal discomfort, respiratory depressi
numbness of the extremities, headache, dizzine
depression, malaise, drowsiness, coma, letha

Many things can cause diarrhea.

LOMOTIL® will almost surely stop it.

The causes of diarrhea are as varied as man's complaints and indiscretions. Because the causes of diarrhea can be obscure and because uncontrolled diarrhea can present serious problems, it is important to know a drug that will usually stop diarrhea promptly. For many physicians, the antidiarrheal drug of choice is Lomotil. It provides almost certain control of diarrhea.

It is also useful in controlling the intestinal transit time of patients with ileostomies and colostomies and the diarrhea occurring after gastric surgery.

Serious side effects are infrequent with Lomotil. It should be used with caution in young children, however, because of their variability in response. Use of Lomotil in children under two years of age is contraindicated.

exia, restlessness, euphoria, pruritus, angioneu-
edema, giant urticaria and paralytic ileus.
ge *and administration:* ***Lomotil is contraindi-***
d in children less than 2 years old. Use only
otil liquid for children 2 to 12 years old. For
2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years,
. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5
daily; adults, two tablets (5 mg.) t.i.d. to two
ts (5 mg.) q.i.d. or two regular teaspoonfuls (10
5 mg.) q.i.d. Maintenance dosage may be as
is one fourth of the initial dosage. Make down-
dosage adjustment as soon as initial symptoms
ontrolled.
osage: Keep the medication out of the reach
ildren since accidental overdosage may cause
e, even fatal, respiratory depression. Signs of
osage include flushing, lethargy or coma, hypo-
reflexes, nystagmus, pinpoint pupils, tachy-
a and respiratory depression which may occur
12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

For the almost certain control of diarrhea,

LOMOTIL®

TABLETS/LIQUID

Each tablet and each 5 ml. of liquid contain:
Diphenoxylate hydrochloride ...... 2.5 mg.
(Warning: may be habit forming)
Atropine sulfate .... 0.025 mg.

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Each Spansule®(brand of sustained release capsule) contains 8 mg. of Teldrin®(brand of chlorpheniramine maleate); 50 mg. of phenylpropanolamine hydrochloride; and 2.5 mg. of isopropamide, as the iodide.

Knows the public's enemies—nasal congestion, runny nose, sneezing, watery eyes.

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All through the dark night of upper respiratory difficulty, while ordinary cold remedies wear off, the decongestant, antihistamine, and drying agent in 'Ornade' fight the never-ending battle for comfort, symptomatic relief, and free airways.

Ornade®. Why not let it help fight your patient's cold war.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Indications: Upper respiratory congestion and hypersecretion associated with: the common cold; acute and chronic sinusitis; vasomotor rhinitis; allergic rhinitis (hay fever, "rose fever," etc.).

Contraindications: Hypersensitivity to any component; concurrent MAO inhibitor therapy; severe hypertension; bronchial asthma; coronary artery disease; stenosing peptic ulcer; pyloroduodenal or bladder neck obstruction. Children under 6.

Warnings: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Warn patients of possible additive effects with alcohol and other CNS depressants.

Usage in Pregnancy: In pregnancy, nursing mothers and women who might bear children, weigh potential benefits against hazards. Inhibition of lactation may occur.

Effect on PBI Determination and I^{131} Uptake: Isopropamide iodide may alter PBI test results and will suppress I^{131} uptake. Substitute thyroid tests unaffected by exogenous iodides.

Precautions: Use cautiously in persons with cardiovascular disease, glaucoma, prostatic hypertrophy, hyperthyroidism.

Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth; nervousness; or insomnia. Also, nausea, vomiting, epigastric distress, diarrhea, rash, dizziness, weakness, chest tightness, angina pain, abdominal pain, irritability, palpitation, headache, incoordination, tremor, dysuria, difficulty in urination, thrombocytopenia, leukopenia, convulsions, hypertension, hypotension, anorexia, constipation, visual disturbances, iodine toxicity (acne, parotitis).

Supplied: Bottles of 50 capsules.

SK&F *Smith Kline & French Laboratories*

Zip code 48823

Gov. Milliken answers MSMS letter on physician's assistants

(The following letter was received Jan. 29 at MSMS headquarters. It was addressed to John J. Coury, Jr., MD, MSMS president)

Dear Dr. Coury:

Thank you for your recent letter regarding the physician assistants bill, House Bill 4056. I want you to know that I considered very carefully arguments for and against this legislation before deciding to sign the Bill into law. I am convinced that its enactment is in the best interest of Michigan citizens.

In the first place, many areas of the State are experiencing health manpower shortages. With the aid of physician assistants, existing personnel will be able to make more effective use of their time in providing needed health care.

The Bill establishes a Commission to develop necessary criteria for the education, training, and experience required of physician assistants; to make recommendations with regard to training programs; and to monitor the utilization of physician assistants in Michigan.

While allowing thorough study and experimentation, the Bill provides a framework within which rational decisions can be made concerning the role, utility, and education of physician assistants. The flexibility afforded by this approach is highly desirable at a time when innovations are occurring rapidly in the field of health care.

Again, thank you for expressing your views on this important piece of legislation.

Kind personal regards.

Sincerely,

William G. Milliken
Governor

Social Services Department to begin Medicaid screening in April

To the editor:

The January 1973 edition of *Michigan Medicine* made reference to the Medicaid early and periodic screening, diagnosis and treatment program for children under 21 (p. 11, MSMS Action).

We appreciate your interest in the screening program. However, we would like to clarify one point with respect to Michigan's noncompliance with the Federal implementation schedule.

The U.S. Department of Health, Education and Welfare did release a news bulletin stating that Michigan was one of only two remaining states not yet implementing the program. However, a review of the facts indicated that only seven of the fifty states had, in fact, implemented a program of early screening, diagnosis and treatment. This was acknowledged at a later date by H.E.W.

The Michigan Departments of Social Services and Public Health have been making preparations for some time to provide a program of screening and treatment for children under the Medicaid Program. On January 3, 1973, the Legislature provided the necessary appropriation enabling us to go forward with the program.

We are pleased that we will be able to begin the screening program the first of April, as originally planned. We would like to thank the Michigan State Medical Society for its public support of this effort. Michigan's doctors will serve a vital function in ensuring the success of this important preventive health care program.

Paul M. Allen, Director
Bureau of Medical Assistance

Tecumseh Doctor decries physicians' "hypocrisy" toward human fetus

To the Editor,

I read with considerable interest your very amusing article on "Infant Mortality in Michigan" in the Jan. issue of *Michigan Medicine.* I say amusing because it is the only kind word I can think of to describe the hypocritical attitude of the Michigan State Medical Society concerning the status of the unborn fetus. Just last November the Michigan State Medical Society was doing its best to promote "scientific medical abortion" based on the sacred cow of the "patient-doctor" relationship deciding whether the unborn fetus is a living human or not. They were ably assisted by many "experts," such as those who are so concerned in your article about the life of the unborn fetus. Now all of these people are counting calories, protein intake, nutrition, salt, infant mortality rates, JUST AS THOUGH the unborn fetus were a real live human, worth saving. Can you really prove the unborn fetus is a live human and worth counting calories and salt for?

In my letter published in the *American Medical News* on Nov. 20, 1972, I discussed Harry the lowering of "infant mortality" — legalize abortions and then make it illegal to count them as "mortalities," because they are not really living humans. This is a major reason so many other countries have a better "mortality" rate than we do — they simply don't count all the dead ones.

Richard Austin, the great pious politician, was quoted by Judd Arnett in the *Detroit Free Press* on Oct. 12, 1972, with his usual crocodile tears over the high "mortality rate" in the poor sections of Detroit. At the same time, he was campaigning for the "cure" — do more abortions and make it illegal to count them as "mortalities." I wrote to both men, asking how they could rationalize large Medicaid fees for abortions, and then expect doctors to work for low fees in the poor sections of Detroit to improve "infant mortality." I also pointed out the current abortion rate in San Francisco is 532 abortions for every 1000 live births, so why worry about "infant mortality"? Naturally, neither gentleman answered my letter.

Dr. Berger, (C.J. Berger, MD, acting director, Detroit Maternal and Infant Care Project) of course, took the position that an unborn fetus is not a living human being until the glorious State of Michigan, in all its medical knowledge and majesty, says it is. Meaning that life is a privilege to be granted by those in power, the politicians, like pious Mr. Austin, who is now back on the track of "saving infant lives in the poor sections of the city."

Among many other physicians, I do not accept the cruel, mindless, and brainless hypocrisy of the Michigan State Medical Society, that the unborn fetus is a living human when we count calories, proteins, "mortality statistics" that do not include all the dead ones; and is not a living human being when we adopt the sacred cow of the "patient-doctor" relationship deciding on the legality of "medical abortion" because life is a privilege to be denied for a proper, usual-and-customary fee.

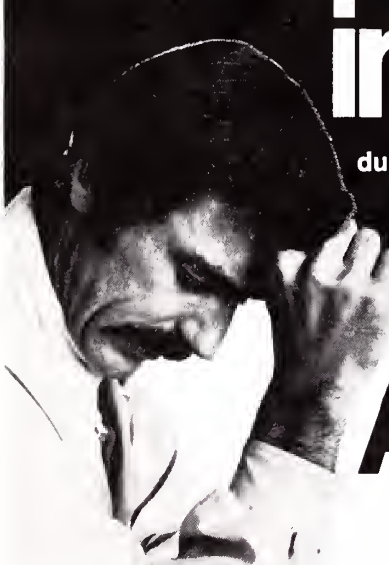
Next time, you should quote better "experts" on "infant mortality."

Sincerely yours,
Edward J. Dranginis, MD

Doctor Berger
replies to Dr. Dranginis:

Your letter commenting on the article "Infant Mortality in Michigan" (Jan. 1973) prompts me to make these brief comments: (1) Fetal deaths occurring prior to 20 weeks of gestation have not been part of statistics collected here in Michigan or in any of the developed, civilized nations of Europe and would play no role in affecting differences in

(Continued on page 238)



The treatment of
impotence
due to androgenic deficiency in the American male.
The concept of chemotherapy plus the
physician's psychological support is confirmed
as effective therapy.

NEW CLINICAL STUDY

The Treatment of Impotence
with Methyltestosterone Thyroid
(100 patients — Double Blind Study)
T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the
American Fertility Society

Android®
(thyroid-androgen) tablets

Double-Blind Study and Type of Patient:
100 patients suffering from impotence. Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% on placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

Choice of 4 strengths:

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Each yellow tablet contains:
Methyl Testosterone ..2.5 mg.
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Glutamic Acid ....50 mg.
Thiamine HCL ....10 mg.
Dose: 1 tablet 3 times daily.
Available:
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REFER TO PDR

Android-HP
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Thiamine HCL ....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY
Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid ....50 mg.
Thiamine HCL ....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGH POTENCY
B-COMPLEX AND VITAMIH C
Each white tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (¼ gr.) ...15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL ....25 mg.
Glutamic Acid ....100 mg.
Pyridoxine HCL ....5 mg.
Niacinamide ....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 ....2.5 mcg.
Riboflavin ....5 mg.
Dose: 2 tablets daily.
Available: Bottles of 60, 500.

Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiorenal disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

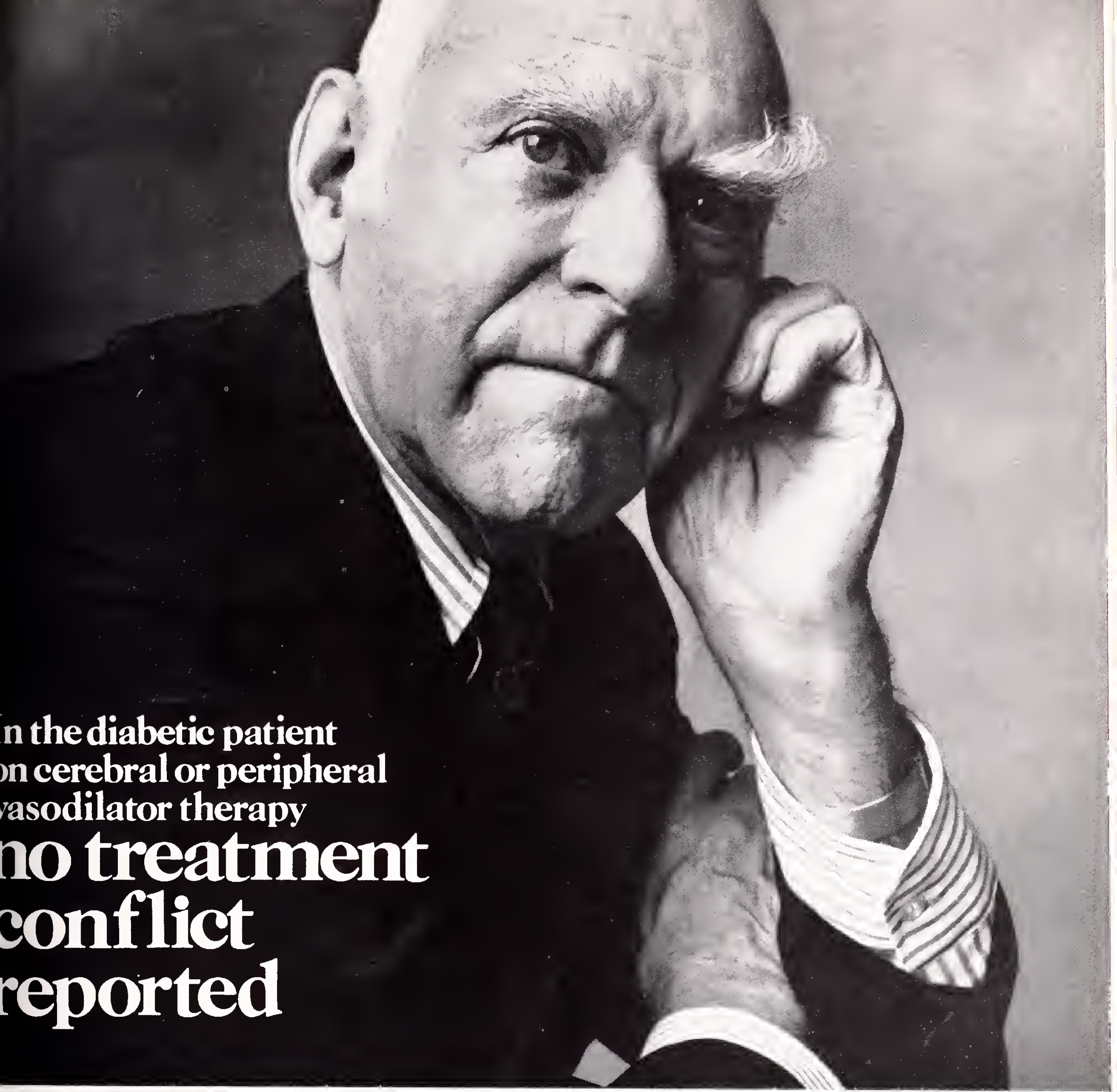
Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.

Hypercalcemia may occur, particularly in immobilized patients; use of Testosterone should be discontinued as soon as hypercalcemia is detected

References: 1. **Monteeano, P., and Evangeliste, t.** Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotence, Gen Prac 25:6, 1962 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25), Lippincott, Philadelphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

Write for literature and samples: BROWN THE BROWN PHARMACEUTICAL CO., INC. 2500 West 6th Street, Los Angeles, California 90057



VASODILAN®
(ISOXSUPRINE HCl)
the compatible vasodilator

- no interference with diabetic control . . . does not alter carbohydrate metabolism.[1]
- conflicts have not been reported with diuretics, corticosteroids, antihypertensives or miotics.

There are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

INDICATIONS: Based on a review of this drug by the National Academy of Sciences–National Research Council and/or other information, the FDA has classified the indications as follows:
Possibly Effective:
1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

OMPOSITION: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

DOSAGE AND ADMINISTRATION: 10 to 20 mg. three or four times daily.

CONTRAINDICATIONS AND CAUTIONS: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

ADVERSE REACTIONS: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

SUPPLIED:
Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose
20 mg.—bottles of 100, 500 and Unit Dose

REFERENCE: 1. Samuels, S. S., and Shaftel, H. E.: J. Indiana Med. Ass. 54:1021-1023 (July) 1961.

Mead Johnson
LABORATORIES

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Schwartz's book and his great "contribution" to *infant mortality* rates various countries report. Were the United States statistics to include all fetal deaths (even prior to 20 weeks) our relative infant mortalilty standing would appear at an even greater disadvantage than its current unenviable position. (2) Never to my knowledge have I ever conferred upon the State the right to define at which point an unborn fetus becomes a living human being but I have insisted on the right of all citizens to act in consonance with their individual consciences and personal standards of morality. You, on the other hand, would deny the ability to abort early pregnancies to those whose sincerely-held, formed in good faith convictions differ from your own.

Charles J. Berger, M.D., FACS

NATAL to continue fight against abortion

Feb. 2, 1973
To the Editor,

Nurses Associated To Assure Life, (NATAL) representing over 800 nurses throughout the United States and responding to the recent U.S. Supreme Court decision to permit abortion on the request of the mother to 6 months, wishes to assure the nation that our primary goal will be to educate the public, including 7 Supreme Court Justices, on the life and development of unborn children and the clinical procedures of pregnancy termination.

We feel that if human life is valuable, it must be protected at all stages of development. The destruction of a 12 week fetus is as great a crime against humanity as the destruction of a newborn. The only difference is that of size, maturation and the physical act of birth.

The 14th Amendment to the U.S. Constitution reads, "No state shall deprive any person of life, liberty or property without due process of law." No word in the constitution as amended, qualifies life as having to be any specific age, degree of genetic perfection, state of dependency or acceptability in order to share in the protection of our republic.

This is not the first time in American history that individuals have been legally dehumanized and denied equal protection under the law. It is not the first time that Americans have had to speak out for basic human rights.

Nurses can now voice their concern through Nurses Associated to Assure Life, and NATAL needs the support of all concerned citizens.

Sincerely

Sheila Johnson, R.N.
Beverly E. Smith, L.P.N.
Ellenor Boardman, S.N.

NATAL
P.O. Box 5434
Lansing, Michigan 48905

Know your Auxiliary, medical assistants

The following are the names and addresses of the officers of the Woman's Auxiliary to MSMS and the State of Michigan Branch, American Association of Medical Assistants.

Woman's Auxiliary to MSMS

President — Mrs. Fleming Barbour, 2015 Lincoln Drive, Flint, 48503.

President-elect — Mrs. William J. Jones, 15839 Crescent Drive, Allen Park, 48101.

First vice-president — Mrs. S.A. Yannitelli, 28 Woodmer Lane, Battle Creek, 49017.

Second vice-president — Mrs. Willis L. Dixon, 2012 Coronado Drive, SE, Grand Rapids, 49506.

Recording secretary — Mrs. Marvin Bonzelaar, 3044 Bonita Drive, SE, Grand Rapids, 49508.

Corresponding secretary — Mrs. Carl Mangelsdorf, 1201 Woodslea, Flint, 48507.

Financial secretary — Mrs. Joseph Loree, 309 Valerie Court, Essexville, 48732.

Treasurer — Mrs. Alan B. Varley, 2146 Treehaven, Kalamazoo, 49008.

State of Michigan Branch, AAMA

President — Miss Margaret Broadwell, 406 Professional Plaza, 3800 Woodward, Detroit, 48201.

Vice-president — Mrs. Louise Cole, 215-A South Main, Ann Arbor, 48108.

President-elect — Mrs. Audrie Chute, 3600 W. 13 Mile Road, Royal Oak, 48072.

Recording secretary — Mrs. Ruth Hendricksen, 31815 Southfield Medical Village, Suite 32, Birmingham, 48009.

Treasurer — Mrs. Elaine Roekle, 1703 Durand, Saginaw, 48602.

Speaker of the House — Mrs. Lee Bosard, 1025 Huron Ave., Port Huron, 48060.

Corresponding Secretary — Miss Patricia L. Gamburd, 4397 Alter Road, Detroit, 48215

"The history of science, and in particular the history of medicine . . . is . . . the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."

—George Sarton, from "The History of Medicine Versus the History of Art"

Are there significant differences in bioavailability and clinical predictability among drug products?

Opinion

Results of a questionnaire to 7,000 physicians:

44.6%
Agree there is a significant difference

24.9%
Believe there is no difference

30.5%
Had no opinion

Are there significant difference in bioavailability and clinica predictability among drug products

Teacher of Medicine

Alfred Gilman, Ph.D.
Wm. S. Lasdon
Professor & Chairman
Department of
Pharmacology
Albert Einstein
College of Medicine of
Yeshiva University

I think that there can be a very great distinction between generic drugs and brand name drugs. And that applies to products of original research that have outlived their patent protection as well as to drugs that have long been in the public domain. Let me explain why.

The Importance of the Manufacturing Environment

In terms of formulation, quality control, and the ability to reproduce an essentially identical product, batch after batch, I doubt that many firms are properly equipped to put out a product that is as carefully controlled as the product marketed by a pharmaceutical company with sophisticated research and high quality manufacturing facilities. For example, when a company comes out with its own preparation of a drug that has just lost its patent protection, there is no assurance that the drug it produces will be a therapeutic equivalent. The raw material could be identical and yet bioavailability might vary from complete unavailability to that which is equivalent to the original.

It Isn't Enough to Meet USP and NF Standards

Meeting USP and NF standards is not enough to guarantee therapeutic equivalence. In certain instances, stricter standards must be applied. Right now, the New York Heart Association has a committee that is studying the problem of digoxin equivalency. I am certain that they are going to recommend a bioavailability assay of a particular digoxin. Unless this is done, they will not recommend it for purchase or use in New York City hospitals. It represents too much of a hazard. They have gone so far as to recommend a batch-by-batch certification of bioavailability even though the company has been reproducing and marketing a digoxin product through the years.

The Problem of Controlling Bioavailability of Generics

The FDA does not have the manpower to inspect the quality control capabilities of hundreds of houses specializing in generic products. And I don't think that the average pharmacist is knowledgeable or aware of the quality and bioavailability of the infinite numbers of generic preparations. A recommendation has been made that every time a generic house (or for that matter a large pharmaceutical company) markets an already existing drug for the first time, a modified new drug application should be submitted. The manufacturer would have to show that his compound is the therapeutic equivalent of the standard compound in use, assuming that the standard compound is one that has been available for an extended period—say 15 years. This would be one indication that the control of bioavailability is beginning to get the attention that it deserves.

Clinical Predictabilit
More Important Than P

Although the questio
price has been greatly
aggerated, it is true t
patients can on occas
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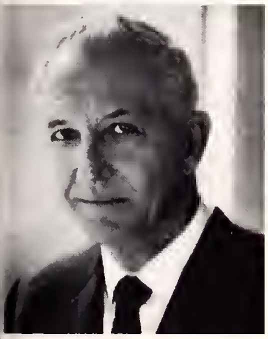
Maker of Medicine

C. J. Cavallito, Ph.D.
xecutive Vice President
Ayerst Laboratories



Although equivalence of ferent preparations of a ıg *substance* may be de- ed by certain physical, mical or biological char- eristics, identity is not ays assured even though se characteristics may described in compendia h as the USP, NF or de- ed by other specific ırce standards. More- r, even with equivalent ıg substances, similar armaceutical *products* ı be produced by differ- manufacturers such t these products are bio- ically or therapeutically quivalent.

A Growing Awareness of Potential for Nonequivalence

As experience increases h drug substances de- ed from different sources 1 under different condi- ns, it should be possible stablish specifications in ficient detail to minimize potential for their non- uivalence. However, re is general agreement it product therapeutic uivalence would still not assured even if one could minimize nonequivalence of drug components produced by different manufacturers. Arguments relate largely to the extent of product inequivalences. Experience over the past six years has uncovered a greater incidence of nonequivalence of products prepared by different manufacturers from generically equivalent substances than many had previously surmised.

Newer Bioavailability Studies Reveal Differences

Bioavailability may be defined as a measure of the rate and amount of absorption of a drug substance from its administered dosage form. For several years pharmaceutical scientists have proposed that bioavailability data on presumably equivalent dosage forms provide the best measure of product equivalence—short of adequate clinical trial. In their continued search for shortcuts to the evaluation of product equivalence, medical and pharmaceutical scientists have increasingly relied upon bioavailability characteristics as reflected by blood levels of a drug after its administration to human subjects.

Leading manufacturers now conduct comparative bioavailability studies on their own product dosage forms after production process changes that would have been considered inconsequential a few years ago. This isn't surprising, since there are so many possible differences in production operations that the opportunities for inequivalent generic and brand name products are numerous—even when the production process begins with identical chemical substances. Moreover, reputable manufacturers are striving to improve *in vitro* control measures, such as dissolution characteristics, which are being related more meaningfully to bioavailability reference data.

As a result of advances in scientific instrumentation and analytical methodology which permit measurements of small quantities of drug substances in the body, our abilities to detect differences in bioavailability and possible therapeutic nonequivalance have appreciably improved.

Product Selection Based on Patient Response

Improved specifications and standards can better assure the equivalence of *drug substances*. Manufacturers, compendia and regulatory agencies can all play a part. However, it is the *drug product*, not the *drug substance*, that the physician, pharmacist, nurse and patient-customer utilize. How can these individuals make or influence specific product selections to minimize variations in therapeutic equivalence of multisource drugs? Patients' responses to a drug product provide a basis of experience to aid the physician in his selection of a particular product. The nurse and pharmacist can also help detect patient responses, but ultimate responsibility must remain with the physician.

Reputation of Manufacturer as Basis for Product Selection

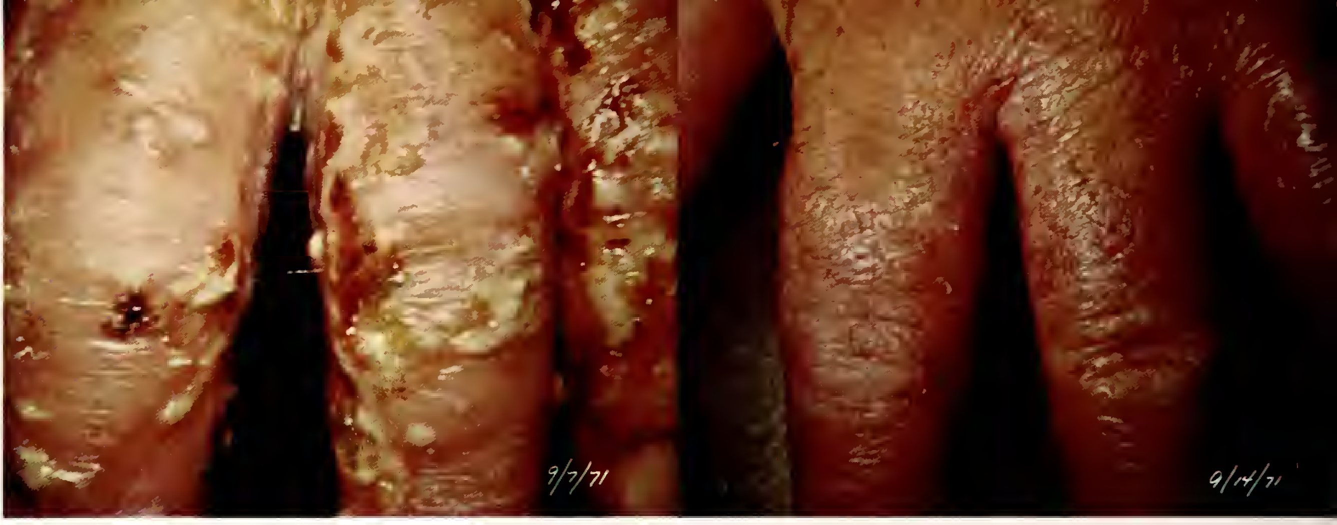
The physician, to assure that his patients receive quality health care, must rely upon the capabilities of the reputable pharmaceutical manufacturer who is equipped to develop, prepare and control a quality product of uniform, reliable therapeutic performance. Substitution with purportedly equivalent generic products that are only superficially evaluated by an imitator manufacturer can place the health of the patient secondary to factors of price or convenience for the provider.

Opinion & Dialogue

What is your opinion, doctor?
We would welcome your comments.

P·M·A

The Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005



MINOCIN® made the difference in just eight days.*

Clinical Data:

Patient: 47-year-old male.
Diagnosis: Severe pyoderma, left hand.
Culture: *Staphylococcus aureus, coagulase* positive and sensitive to MINOCIN.
Temperature: 102° F
Therapy: MINOCIN Minocycline HCl Capsules, 100 mg: 200 mg *stat,* 100 mg every 12 hours. Medication began 9/7/71. By fourth day, temperature was normal and pustular lesions considerably improved. Last dose taken 9/14/71.
Concomitant therapy: None.†

Semisynthetic
MINOCIN®
MINOCYCLINE HCl
Capsules, 100 mg: 2 *stat,* 1 q 12 h.

Indications: For the treatment of susceptible infections; *e.g., E. coli, D. pneumoniae.* For full list of approved indications consult labeling.

Contraindications: Hypersensitivity to any tetracycline.

Warnings: The use of tetracyclines during tooth development (last half of pregnancy, infancy and childhood to the age of 8 years) may cause permanent discoloration of the teeth (yellow-gray-brown). This is more common during long-term use but has been observed following repeated short-term courses. Enamel hypoplasia has also been reported. Tetracyclines, therefore, should not be used in this age group unless other drugs are not likely to be effective or are contraindicated. In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, use lower total doses, and, in prolonged therapy, determine serum levels. Photosensitivity manifested by an exaggerated sunburn reaction has also been observed in some individuals taking tetracyclines. Advise patients apt to be exposed to direct sunlight or ultraviolet light that such reaction can occur, and discontinue treatment at first evidence of skin erythema. Studies to date indicate that photosensitivity does not occur with MINOCIN Minocycline HCl. In patients with significantly impaired renal function, the antianabolic action of tetracycline may cause an increase in BUN, leading to azotemia, hyperphosphatemia, and acidosis. CNS side effects (lightheadedness, dizziness, vertigo) have been reported, may disappear during therapy, and always disappear rapidly when drug is discontinued. Caution patients who experience these symptoms about driving vehicles or using hazardous machinery while taking this drug. *Pregnancy:* In animal studies, tetracyclines cross the placenta, are found in fetal tissues, and can have toxic effects on the developing fetus (often related to retardation of skeletal development). Embryotoxicity has been noted in animals treated early in pregnancy. Safety of use during human pregnancy has not been established. *Newborns, infants and children:* All tetracyclines form a stable calcium complex in any bone-forming tissue. Prematures, given oral doses of 25 mg./kg. every 6 hours, demonstrated a decrease in fibula growth rate, reversible when drug was discontinued. Tetracyclines are present in the milk of lactating women who are taking a drug of this class.

Precautions: Use may result in overgrowth of nonsusceptible organisms, including fungi. If superinfection occurs, institute appropriate therapy. In venereal diseases when coexistent syphilis is suspected, darkfield examination should be done before treatment is started and blood serology repeated monthly for at least four months. Because tetracyclines have been shown to depress plasma prothrombin activity, patients on anticoagulant therapy may require downward adjustment of such dosage. Test for organ system dysfunction (*e.g.,* renal, hepatic and hemopoietic) in long-term use. Treat all Group A beta hemolytic streptococcal infections for at least 10 days. Avoid giving tetracycline in conjunction with penicillin.

Adverse Reaction: GI: (with both oral and parenteral use): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in anogenital region. *Skin:* maculopapular and erythematous rashes. Exfoliative dermatitis (uncommon). Photosensitivity is discussed above ("Warnings"). *Renal toxicity:* rise in BUN, dose-related (see "Warnings"). *Hypersensitivity reactions:* urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus. In young infants, bulging fontanels have been reported following full therapeutic dosage, disappearing rapidly when drug was discontinued. *Blood:* hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia. *CNS:* (see "Warnings.") When given in high doses, tetracyclines may produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

NOTE: Concomitant therapy: Antacids containing aluminum, calcium, or magnesium impair absorption; do not give to patients taking oral minocycline. Studies to date indicate that absorption of MINOCIN is not notably influenced by foods and dairy products.

***Indicated in infections due to susceptible organisms. Culture and sensitivity testing recommended. Tetracyclines are not the drugs of choice in the treatment of any staphylococcal infection.**

†Case Report, Clinical Investigation Department, Lederle Laboratories.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 10965 12-20 436-2

County scenes

Auxiliary brochure welcomes new doctors to Flint

"Welcome, Doctor . . . to the City of Flint," reads the cover of the bright green packet now in the hands of residents and interns in that community.

The packet, a warm greeting to new doctors from the members of the Auxiliary to the Genesee County Medical Society, contains letters from the mayor and the president of the medical society, names and addresses of the Flint-area churches, schools, shopping centers, hotels, motels and restaurants.

Also included are a map of Flint, the general statistics of the area, guides to outdoor recreation in Michigan, pamphlets on the cultural, recreational and educational programs of Flint, and guidelines to day care, safety and volunteer programs in the city.

The packet was the idea of Mrs. Paul Morin, Genesee County Auxiliary member, who was assisted by Mrs. Fleming Barbour, State Auxiliary president. Mrs. Morin gathered most of the materials for the brochure from the Flint Chamber of Commerce.

The medical society supplied the folders and had them printed with the "Welcome, Doctor . . . " message. Then, last summer, as the new interns and residents in Flint began their work, Mrs. Morin delivered 50 of the packets to directors of medical education at the hospitals.

"The packets were graciously received by our new doctors," reports Mrs. Carl Mangelsdorf, finance chairman of the Genesee Auxiliary and coresponding secretary for the state society. "We have heard that they were especially useful to foreign intern and resident families."

The Genesee Auxiliary's project has attracted attention throughout its community and around the state.

The Director of Medical Education at McLaren General Hospital, Nancy Furstenberg, MD, a newcomer to Flint, kept one of the kits herself. And leaders of the Michigan State University College of Human Medicine's student externship program have asked that similar folders be distributed to the students who study in Flint.

The State Auxiliary has adopted the Genesee project, dubbed "Tel-an-intern," as one of the five points of its 'Telstar' community relations program for 1973.

The Genesee Auxiliary plans to complete more packets by July 1 for new interns and residents who will be establishing residence in this city. Mrs. Morin already has ideas for more materials to be inserted in the big green folder.

"Wouldn't it be nice," she muses, "if we could add a list of grocery stores and restaurants where the foreign families could purchase their native foods . . . "

The Ottawa County Medical Society recently presented a series of programs in Grand Haven and Holland for schools and other groups about drug abuse. Speaking at one of the meetings are, left to right, Rev. Vaughan Quinn, Detroit; Dennis Seeley, chief of the Michigan Department of Public Health drug abuse unit, and M. G. Robertson, MD, Grand Haven, chairman of the Ottawa medical society committee on public relations.

Kent County honors team physicians

Thirteen doctors who have served five years or more as physicians to area athletic teams were honored by the Kent County Medical Society in a special meeting Feb. 13. The physicians were invited to bring athletic directors from their schools as guests, and sports editors from local newspapers were included, also. Speaker at the meeting was Arthur E. Ellison, MD, Williamstown, Mass., physician for the winter U.S. Olympics team. He discussed prevention and treatment of ski injuries.

Extra tickets provide 'night out' for Saginaw doctors

Doctor, do you have some extra tickets to a symphony concert? the theater? basketball games at the University of Michigan, Wayne State or MSU?

If so, and particularly if you live in the Saginaw area, the members of the Auxiliary to the Saginaw County Medical Society are interested.

They have a unique plan for using those tickets. They have a list of 25 medical students, interns and residents in the Saginaw area to whom they make those tickets available, graciously offering the young student or doctor an inexpensive night out.

The donate-a-ticket plan was first carried out during the 1971-72 year by Mrs. Benjamin Mayne II, Saginaw auxiliary member. She passed the responsibility on to Mrs. Billy Irons and Mrs. Louis Constan, both wives of Saginaw resident physicians and courtesy members of the auxiliary.

The response to their novel idea has been slight. "I guess the word just hasn't gotten around," Mrs. Irons says, although a small announcement of the auxiliary's desire for unused tickets appeared in the November bulletin of the Saginaw society.

"But if someone has no use for their tickets, we'd like them to call us." Mrs. Iron's telephone number is (517) 752-5032, and Mrs. Constan's number is (517) 755-2825.

U. P. Med Society plans 80th annual meeting

The Pine Mountain Lodge in Iron Mountain will be the scene of the 80th annual meeting of the Upper Peninsula Medical Society June 15-16. A broadly-based medical program for general practitioners is planned, with a session on medical socio-economic problems tentatively on the agenda.

Leading the speakers for the two-day session will be Ray W. Gifford, Jr., MD, of the Department of Hypertension and Nephritis, The Cleveland Clinic.

Nearly 100 physicians from the Upper Peninsula and northern Wisconsin are expected for the meeting by chairman John Schroeder, MD, Iron Mountain, and his committee members: Donald Jacobs, MD; Warren Roberts, MD, John Newkirk, MD; Richard Cecconi, MD, and Ralph Carlson, MD, all of Iron Mountain, and Robert Stelle, MD, Crystal Falls.

Dear Doctor:

This month's "Bio-Science Reports," on the page opposite, is another service of Bio-Science Laboratories.

From time to time, you'll be seeing different reports in Michigan Medicine dealing with laboratory medicine as it applies to your clinical practice.

Over the past 25 years, physicians such as yourself have found that our laboratory service provides a continuing source of accurate results and helpful literature.

Please use the coupon at the bottom of the "Bio-Science Reports" to request any information about our services, fees, or free starter materials.

We are looking forward to serving you.

Sincerely,

Donald C. Cannon

Donald C. Cannon, M.D., Ph.D.
Director

25 YEARS
Bio-Science Laboratories

Bio-Science Reports

Vitamin B_{12} and Folate Assays:

Why and when

Depletion of Vitamin B_{12} is the paramount feature of pernicious anemia and is a pathogenetic factor in most cases of the megaloblastic syndrome. In true pernicious anemia or following total gastrectomy, the B_{12} deficiency arises from a selective absorption defect caused by the absence of intrinsic factor, a glycoprotein secreted in normal gastric juice. Vitamin B_{12} deficiency may also occur from various other causes, most important of which are the various malabsorption syndromes. Serum levels are a reliable indication of Vitamin B_{12} nutrition when liver disease and myeloproliferative disorders can be ruled out. Hepatocellular damage, especially viral hepatitis, can cause release of Vitamin B_{12}-binding protein into the blood, thus facilitating an increase in Vitamin B_{12} levels.

Serum B_{12} is decreased in:

- Pernicious anemia
- Malabsorption syndrome
- Gastrectomy
- Lesions of the small intestine — ileal resection, blind loop, strictures, diverticulosis, anastomosis, regional enteritis
- Nutritional vitamin deficiency
- Pregnancy
- *Diphyllobothrium latum* infestation

Serum B_{12} is increased in:

- Acute and chronic myelogenous leukemia
- Polycythemia vera
- Myeloid metaplasia
- Liver disease — cirrhosis, hepatitis

Megaloblastic anemias of infancy and pregnancy are frequently the result of folate deficiency. Infants with various pathological conditions are predisposed to folate deficiencies. Rapidly growing tissues and intensive hematopoiesis to meet the steadily expanding blood volume increase the demand for folate. Reserves are low even in healthy infants, especially those fed with heated cow's milk. Any infection may produce a clinical deficiency state.

Although some infants with megaloblastic anemia respond to small doses of Vitamin B_{12}, this therapeutic "cross-effectiveness" has not yet been fully explained and treatment with the "wrong" vitamin is potentially dangerous. In megaloblastic anemias cytological examinations cannot establish the specific etiology. Since diagnosis by therapeutic trials is cumbersome, the investigation of serum levels of both compounds is indicated.

Borderline serum folate levels are difficult to interpret in those patients with little or no hematologic changes. In such cases the measurement of red blood cell (RBC) folate levels (where B_{12} deficiency has been excluded) will provide an accurate quantitative guide to the severity of folate deficiency. When RBC folate is subnormal the indications are a severe depletion of the folate content of both the hemopoietic and liver cells.

Bio-Science Laboratories

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FREE HANDBOOK OF SPECIALIZED DIAGNOSTIC LABORATORY TESTS

Gentlemen: Please send me, without obligation:

☐ A copy of your Handbook of Specialized Diagnostic Laboratory Tests

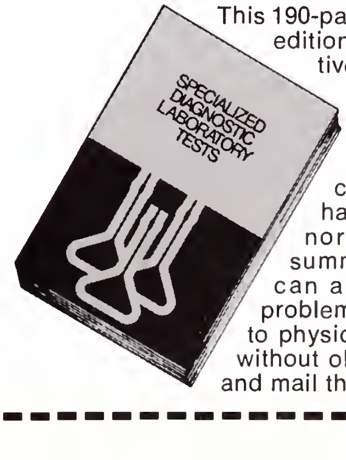
☐ A starter lab pack containing a small supply of postage-paid mailing containers and Fee Schedule

☐ Information on ______________________
(write in name of test)

Name ______________________

Address ______________________

City ______________ State ______________ Zip ______________



This 190-page book, now in its ninth edition, is a uniquely informative source to keep you up-to-date on the newer laboratory tests, such as Vitamin B_{12} and folate, available to clinicians. You will find it a handy reference guide for normal values and quick summations on tests which can aid in your diagnostic problems. Copies are available to physicians and lab personnel without obligation. Simply fill out and mail this coupon.

The chance to observe the activity of a hospital emergency room or operating theater was the goal in mind when Tom Albert, Lansing, sought the counsel of C. Carl West, MD, Lansing, at the recent meeting of the Ingham Medical Explorers Post.

Doctor West, adult advisor to the group since its beginning seven years ago, discussed the AMA booklet *Horizons Unlimited* with, from left, Lori Smith, Williamston, Jennifer Ohl, Lansing, Bill Tafel and Denise Brogan, Williamston.

Ingham Medical Explorer Post #310 is headed by Jennifer Ohl, Lansing, who was able to join the boy Scout post as the Explorers went coeducational nationally in recent years. Now the girls outnumber the boys in this post three to one. Jennifer is flanked here by O. Steward Erhard, MD, Eaton Rapids, first speaker of the year, who described family medicine. The Ingham County Medical Society is co-sponsor of the post.

Ingham doctors introduce Explorer Scouts to medicine

Approximately 40 high school students from Ingham County were present at the opening meeting Jan. 8 of the Medical Explorers. They meet semi-monthly January through May at MSMS headquarters in East Lansing for a varied schedule of speakers and field trips which introduce them to medicine and the allied health careers.

Ancillary

Wayne Alumni Clinic Day has human sexuality as theme

"Human Sexuality: The physician as counselor," is the theme of the 105th annual Clinic Day and Alumni Reunion Banquet planned May 9 by the Wayne State University School of Medicine Alumni Association.

Wardell B. Pomeroy, PhD, who was associated with Alfred Kinsey's Institute of Sex Research for 20 years will be keynote speaker for the event at the Detroit Hilton Hotel. His topic will be "Communicating with patients about sex."

New regulation of x-ray equipment explained

Michigan physicians using x-ray equipment are not required now to upgrade all such equipment under federal regulations, although the FDA reports that some dealers have been advising physicians to that effect.

New regulations, according to John C. Villforth, Director, Bureau of Radiological Health, FDA, require that manufacturer-certified components installed in such x-ray systems after next Aug. 15 must meet the radiation safety performance standard for diagnostic x-ray equipment established by PL 90-602.

MSU medical school expands affiliations; changes administration

MSU's College of Human Medicine has made two new administrative advances.

First, it has affiliated with McPherson Community Health Center in Howell, providing for the training of MSU students there.

Second, it has revised and strengthened its central administrative structure for coordinating medical and other health science academic programs.

The MSU Institute of Biology and Medicine, established in 1969 as part of the Office of the Provost, has been replaced with the position of assistant provost for health programs. John C. Howell, PhD, has been named to the new post. He formerly served as associate dean of the College of Human Medicine and of the College of Social Science.

Medical students, Michigan communities to meet April 25

The second "Physicians for Michigan Communities Day" is planned by the Michigan Health Council April 25 at Scott Hall, Wayne State University School of Medicine. Students from the state's three medical schools will have the opportunity to meet with leaders from communities actively seeking new physicians and hoping to recruit them from among the medical schools' student bodies. The first community-student day in 1971 drew over 30 communities and 300 students.

Heart Days April 5-6 in Lansing

The psychological problems of the cardiac patient will be the subject at the 24th annual Heart Days April 5-6, sponsored by the Michigan Heart Association. Two days of seminars for physicians and surgeons on the latest developments in diagnosis and treatment of cardiopulmonary diseases are included.

Heart Days will take place at the Civic Center, Lansing. Speakers will include William Castelli, MD, National Heart Institute, Framingham, Mass; Allen J. Enelow, MD, chairman, Department of Psychiatry, University of the Pacific, San Francisco.

SOME PHYSICIANS KNOW what to do with their patients who are alcoholics or problem drinkers.

SOME PHYSICIANS WISH they knew what to do with them.

Have you thought of the Alcoholism Services of the Battle Creek Sanitarium Hospital? Since 1965 we have maintained an enviable record in the rehabilitation of the alcoholic or problem drinker.

A full range of services and specialties.

Give us a call
616-964-7121 Ext. 588 or 589

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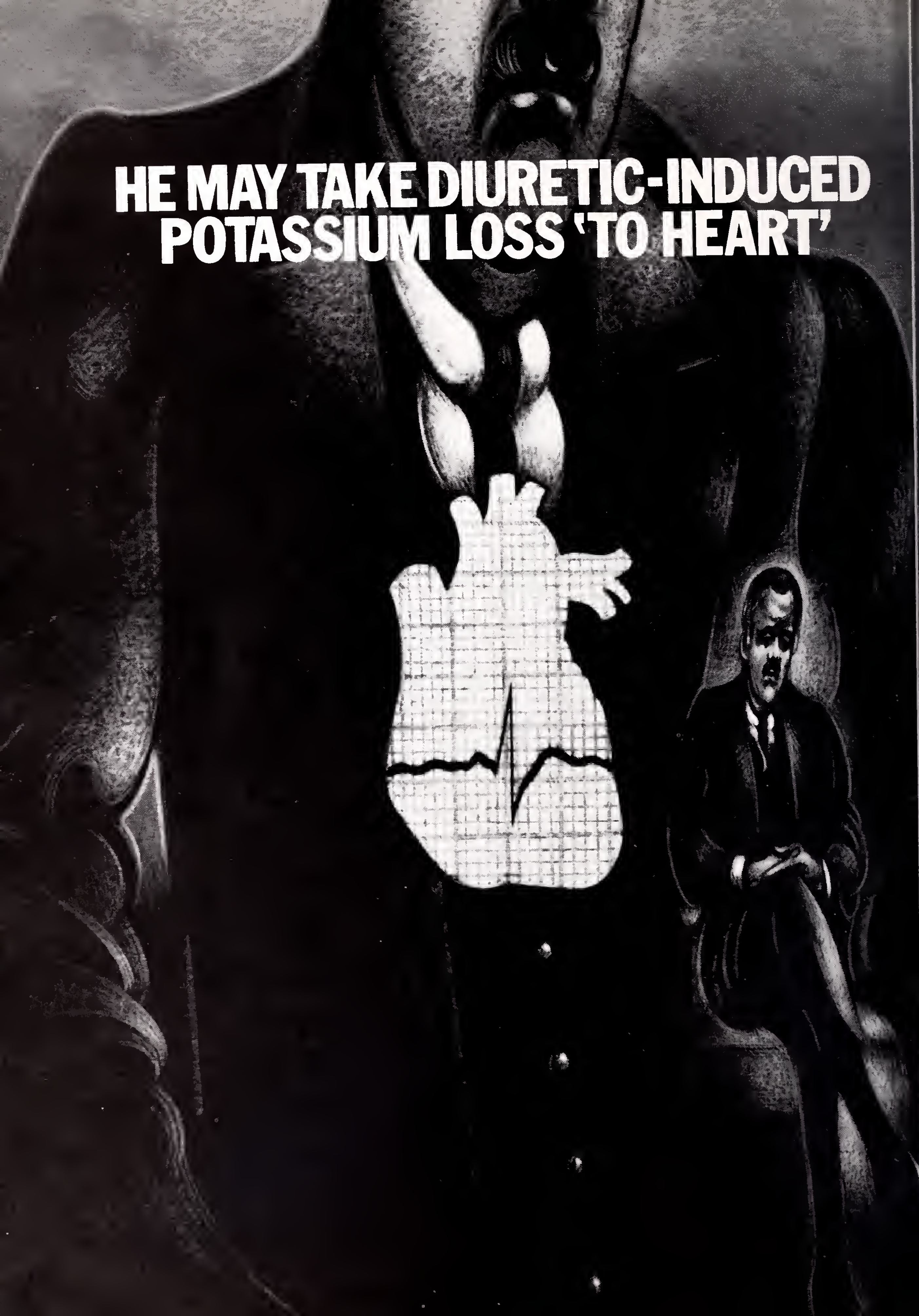
HE MAY TAKE DIURETIC-INDUCED
POTASSIUM LOSS 'TO HEART'

AVOID POTASSIUM DEFICIENCY WITH...

K·LYTE® OR K·LYTE®/CL

potassium supplement — potassium supplement *with* chloride

Manifestations of potassium deficiency may range through a variety of signs and symptoms including muscular weakness and fatigue...cardiac alterations discernible by characteristic ECG tracings...impaired mental function and diminished reflexes...impaired respiration...anorexia and abdominal distention.

The etiology of hypokalemia is also broad, encompassing a number of clinical conditions. But most important of all may be a course of treatment that causes excessive loss of body potassium—such as thiazide diuretics and corticosteroids.

No matter what the etiology, the solution is usually *potassium supplementation.*

What better way to supplement than with K-LYTE or K-LYTE/CL. Effervescent K-LYTE tablets supply the usually recommended dose of 50 mEq. potassium daily in just two tablets. When chloride is also desirable, K-LYTE/CL provides it in the preferred 1:1 ratio to potassium. Both forms are accurate and reliable sources of electrolyte replacement. Administration in "pre-dissolved" form reduces the potential for G.I. irritation. Finally, you have a choice of three delicious flavors—a taste of oranges, tangy lime or fruit punch—all good enough to drive a patient to drink.

K-Lyte® Each effervescent tablet in solution supplies 25 mEq. potassium as bicarbonate and citrate

K-Lyte®/Cl Each dose of powder in solution supplies 25 mEq. potassium chloride

Each tablet or dose must be completely dissolved before taking.
Indications: K-Lyte and K-Lyte/Cl are oral potassium supplements for therapy or prophylaxis of potassium deficiency. Particularly useful when thiazide diuretics or corticosteroids cause excessive excretory potassium losses. **Contraindications:** Impaired renal function with oliguria or azotemia; Addison's disease; hyperkalemia from any cause. **Warnings and Precautions:** Since the amount of potassium deficiency may be difficult to determine accurately, supplements should be administered with caution, and dosages adjusted to the requirements of the individual patient. Potassium intoxication rarely occurs in patients with normal kidney function. Symptoms of potassium intoxication are variable. They include listlessness, mental confusion, and tingling of the extremities. Frequent checks of the clinical status of the patient, ECG, and serum potassium level are desirable. In established hypokalemia, attention should also be directed toward other potential electrolyte disturbances. Potassium supplements should be given cautiously to digitalized patients. To minimize the possibility of gastrointestinal irritation associated with the oral ingestion of concentrated potassium salt preparations, patients should be carefully directed to dissolve each dose completely in the stated amount of water. K-Lyte/Cl contains approximately 20-25 Calories of sucrose per dose which should be considered for patients with restriction of caloric intake. **Adverse Reactions:** Nausea, vomiting, diarrhea, and abdominal discomfort may occur with the use of potassium salts. **Dosage and Administration:** Adults: 1 tablet or dose *completely dissolved*, 2 to 4 times daily, depending upon the requirements of the patient: K-Lyte: 1 tablet (25 mEq. potassium) in *3 to 4 ounces of cold or ice water;* K-Lyte/Cl: 1 dose (25 mEq. potassium chloride) in *6 ounces of cold or ice water.* The normal adult daily requirement is approximately 50 mEq. of elemental potassium. NOTE: *It is suggested that these products be taken with meals and sipped slowly over a 5-10 minute period.* **How Supplied:** K-Lyte: Effervescent tablets—boxes of 30 and 250 (orange or lime flavors). K-Lyte/Cl: Powder, cans of 30 measured doses with scoop (fruit-punch flavor). ℞

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LABORATORIES

Socio-economic

Michigan 14th in physicians, 31st in nurses, 20th in internships

Recently, the magazine, *Lifestyle,* published an article, "The Worst American State" by John Berendt. Many sources of statistical information were quoted.

Following are some reports of where Michigan was ranked in the areas related directly or indirectly with health:

Michigan is 14th in the nation in the ranking of physicians per 100,000 with 131 per 100,000. New York is first with 199 per 100,000, and Mississippi is last with 69 per 100,000. *(Statistical Abstract of the US, 1971)*

Michigan is 31st in the number of nurses per 100,000. Michigan has 277 per 100,000. Connecticut is first with 536 per 100,000 and Arkansas is last with 133. *(Statistical Abstract)*

Michigan is 20th in the number of internships offered per 100,000. Michigan has 7.0 internships per 100,000. New York is first with 13.4. Five smaller states offer no internships. *(Statistical Abstract)*

Michigan ranks 26th in the infant mortality rates published in *Information Please Almanac 1972.* Michigan has 2.03 deaths under one year per 100 live births. Nebraska leads with 1.32 and Mississippi is 50th with 3.06 deaths under one year per 100 live births.

Michigan ranks 7th in motor vehicle death rates, according to the *National Safety Council.* Michigan has 4.1 deaths per 100,000,000 vehicle miles. Connecticut has the best rate with 2.7 and Alaska is last with 7.8.

Michigan rates 5th in deaths caused by flu and pneumonia per 100,000. Michigan had 29.4 deaths per 100,000. Alaska had the best record with 14.6 deaths and Vermont the poorest with 55.3. *(Statistical Abstract)*

Michigan rates 23rd in suicides per 100,000 with 10.0. Rhode Island had the best record of 6.4 and Nevada, the poorest with 26.2. *(Statistical Abstract)*

Michigan rates 34th in homicides per 100,000 with 8.9. North Dakota had the fewest .5, while Georgia had the most 15.3. *(Statistical Abstract)*

Michigan ranks 12th in income per capita with $4,043. Connecticut leads with $4,807 and Mississippi is 50th with $2,561. *(Statistical Abstract)*

Michigan ranks 14th in the percentage of poor people. Michigan had 9.4%. Connecticut was first with only 5.7% while Mississippi was last with 34.9%. *(Statistical Abstract)*

Michigan ranked 23rd in assessed value of property per capita at $2,309. Kentucky led with $5,070 and South Carolina was last with $400. *(Statistical Abstract)*

Michigan ranked 21st in percent of illiteracy. Michigan had 1.6% illiteracy. Iowa was best with 0.7% and Louisiana last with 6.3%. *(Statistical Abstract)*

Michigan was rated 13th in overall final standings as a "good state," compared with 11th in 1931. Connecticut was rated 1st in 1972. Massachusetts was 1st in 1931.

U.S. doctors set new records in patient visits

"Doctor, what do you do all day?"

"What is the primary reason for which patients seek your professional services?"

The National Disease and Therapeutic Index Review for June 1972 indicates that in 1971 private practitioners set a record of 1.5 billion patient contacts, a 2% increase from 1970. Contacts in hospital settings increased by 5%, while office visits declined by a comparable percentage. Contacts with children under 10 years of age declined while all other age groups registered increases. The change in birth rates is further reflected in the 12% decrease in prenatal care visits and the 13% decrease in well baby and child contacts.

"The average practitioner saw increasing numbers of infective and parasitic disorders (+13%), disorders of bones and organs of movement (+8%), mental disorders (+5%) and neoplasms (+5%).

"The general practitioners reported an average of 21.8 patients per day in 1970, while the overall patient contacts for all doctors was 17.6 per day. Pediatricians have the largest daily patient load of 24.3 patients per day, and half of these are under 2 years of age."

—Iowa Medical
Journal, 10/72

U-M midwife ready to begin delivering babies

The first modern nurse-midwife employed by The University of Michigan will soon be delivering babies at Women's Hospital if expected approval is issued from Michigan's attorney general.

The midwife, Margaret E. Craig, RN, received her nursing degree at U-M in 1968 and her midwifery training at Yale University. She delivered 260 infants in New York City before joining Women's Hospital last year.

Legislation discouraging the use of midwives was passed in Michigan in 1925 at the urging of physicians who were appalled by the lack of training and expertise of many practicing midwives early in the century.

But J. Robert Willson, MD, chairman, of the U-M obstetrics and gynecology department, was president of the American College of Obstetricians and Gynecologists in 1970 when it issued a joint statement with its Nursing Associations and with the American College of Nurse-Midwives recognizing members of the latter organization as competent partners in maternity care. Since then, he has actively sought to institute a nurse-midwifery program at U-M.

The shortage of obstetricians was a major factor in the drive to develop satisfactory training programs for nurse-midwives, notes Doctor Willson. "There is little hope of solving the problem by graduating more physicians," he says. "We recognize that trained nurse-midwives are fully qualified to handle normal deliveries."

New regulations govern methadone use

The Governor's Office of Drug Abuse and Alcoholism calls the attention of Michigan Physicians to new regulations of the U.S. Food and Drug Administration governing the use of methadone.

Effective Dec. 15, the new regulations require a two-year dependence upon heroin or other morphine-like drugs prior to admission to maintenance treatment. They also invoke special limitations for treatment of patients under 18 and deal with confidentiality of patient records.

All other paragraphs of the 18 pages of regulations go into effect March 15, except for one which becomes the rule on Sept. 15. It states that a reduction is required in take-home dose levels for patients in an approved program who have a take-home dosage level of more than 100 mg. per day when the regulation becomes effective.

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Michigan's prisons need doctors' help for improved care

By Judith Marr
Managing Editor

Your patients are under tension. They seek more medical help, "to escape from reality and work."

They are anxious, separated from homes, families and normal life routines. A number of them are hostile and as a general rule they have poor health and dental habits.

Their symptoms become magnified, as they have much time to think about them. They have more ulcers.

A large number of them are addicted, and thus are difficult to diagnose, as you must determine whether pain is real or imagined. When it is real, they nevertheless have built up immunities to pain killers and they need more medication than the average person to make them comfortable.

And for those reasons, according to Leo M. Baker, DO, medical director of the State Prison of Southern Michigan at Jackson, the prison physician's work is challenging and humanitarian.

"I've been in this work for seven years and I find it most interesting," says Doctor Baker, who describes the prison physician's work load as much like that of the family physician.

But Doctor Baker needs the help of Michigan physicians to improve the medical care at his hosptial.

For that reason, Doctor Baker recently traveled to MSMS headquarters to outline his needs before the medical society's Committee on Scientific and Educational Affairs.

Doctor Baker is head of the 200-bed hospital, which serves all 5,000 inmates at Jackson and all other seriously ill patients from prison facililties around the state.

During 1972, there were 2,610 patients admitted to the hospital. Among these were 225 patients admitted from other institutions. In the same time, 2,633 patients were discharged.

As Doctor Baker told the Scientific and Educational Affairs Committee his hospital needs another full-time staff physician. It also is in need of consultants in the fields of neurology, internal medicine and urology.

The full-time staff physician would work a 40-hour week, draw good pay and excellent civil service benefits, and rotate on weekends and nights. The consultants, on the other hand, are needed on a weekly or biweekly basis.

Doctor Baker explains that the work is especially suited to residents, a physician who would like part-time work, or a semi-retired physician.

"We have a great amount of daily clinic work, numerous physicals to give plus the usual hospital routine," says Doctor Baker. "We are strapped to get it all done."

Doctor Baker, who was in prison medical work in Missouri for six years before taking the Jackson position last July, also says there is great need of professional liability protection for physicians who give medical care to the inmates, on a staff basis and also as consultants.

He made his presentation at MSMS headquarters as a result of a meeting last year between the AMA and the American Corrections Association, when it was decided that medical care in prisons needed much upgrading. The invitation then was extended by MSMS to a representative of Michigan correctional institutions, for a report on how Michigan physicians could help upgrade the medical care in the state's institutions.

"There is a crying need for people in this field," says Doctor Baker. "We hope to attract more people to it. We certainly need them."

Following Doctor Baker's appearance at MSMS, the MSMS House of Representatives passed a resolution that an ad hoc committee be formed to investigate the legislative restrictions and administrative rules re the delivery of health care in Michigan's penal system, and to make recommendations to the Legislature and Corrections Commission.

Teaching hospitals need not affiliate with med schools

MSMS has received a number of questions from physicians, interns and medical students about whether hospitals with intern and resident training programs must affiliate soon with medical schools.

Here is an answer to a MSMS inquiry from C. H. William Ruhe, MD, director of the AMA Division of Medical Education:

"There is no requirement that hospitals affiliate with medical schools in order to retain approval for internship or residency training programs. The confusion stems mostly from a policy statement adopted by the Association of American Medical Colleges at its annual meeting in the fall of 1972 which included the statements that medical schools should ultimately accept the responsibility for graduate medical education and that all internship and residency programs should be in hospitals affiliated with medical schools.

"There has been no action on such a statement by AMA or other national agencies concerned with accreditation of graduate medical education. So long as institutions are able to meet the 'Essentials' for such programs, they will continue to be approved.

"In some instances community hospitals have been advised that they do not, by themselves, have the breadth and depth of resources to enable them to meet 'Essentials' for various kinds of training programs. In such instances they have been told that it will be necessary for them to effect arrangements with other institutions in order to provide the critical mass of professional talent and consulting services necessary for certain types of graduate medical education. The affiliations with other organizations do not necessarily have to be affiliations with medical schools. Some community hospitals have arranged consortia of two or more hospitals in order to provide the appropriate critical mass.

"There has, however, been a substantial increase in the numbers of community hospitals affiliating with medical schools in the past few years. This has been due partially to the interest of the community hospitals in strengthening their programs through affiliation and partially due to the needs of the medical schools to expand their clinical base because of the rapid expansion of their class size."

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Minding your business: proper record keeping

By John Steffen
William Ellerthorpe
Lansing

Complete and accurate records are the basis upon which many of the decisions regarding the business side of the physician's practice are based.

We recommend you maintain financial receipts and disbursements records through deposits of all cash receipts, and payment of all expenses by check in so far as possible.

The physician should have a ledger which provides a picture of the progress of his practice and his financial position at any given time. The accuracy of all information contained therein is important and since this serves as a "case history" upon which many decisions will be based. Such records are not only important from a good management standpoint but are extremely important and helpful in substantiating income and deductions for Federal Income Tax purposes.

It is important, as we have stressed before, that an accurate accounting be made of all cash received. At the close of each day the total cash received in currency and checks should be equal to the total receipts recorded in the daybook. If and when any discrepancy is found, a notation should be made on the daybook for that day of the amount of the error. Posting from the daybook to the patient's financial card should be done daily so the patient's record is current at all times. Delay in keeping accounts current only encourages errors and ultimately results in a dissatisfied patient if such errors recur. All payments from patients should be receipted.

We emphasize that all business done (office, house and hospital work) should be recorded on the day the service is rendered. All patients seen each day should be recorded on that day regardless of whether there is a charge to be made. Cash receipts should be recorded on the day the money is received in the office. All posting should be done daily to avoid getting behind.

The patient's financial card should show all the information necessary regarding the name and address of the party responsible for payment, the name of third party carriers if the patient is insured under a medical or hospital program and any other comments pertinent to contacting and settlement of the bill.

The date on which statements are sent should be stamped on the patient's financial card to aid in following up the account for payment.

Professional Management has found a well-designed "Peg Board" system of accounting is generally the most efficient way for a busy practitioner's office to keep records. The "Peg Board" creates a charge slip, gives the patient a receipt, an appointment, and an itemized bill. It also posts the patient's financial card and daybook sheet all in one step, eliminating transferring figures from one type of record to another.

All disbursements should be made by check and check stubs clearly labeled to show why the check was written. It will simplify record-keeping if all interest, taxes, contributions, mortgage and note payments (i.e., anything that has tax consequence) are made from the business account. Only personal items should be paid out of the house account.

To meet small, repetitious expenses a petty cash fund should be established as follows: A check should be drawn for any reasonable amount, say $25 or $50, depending upon requirements. This money should be kept separate from any other cash items. An accurate account of all expenses from this fund should be kept until one-half to two-thirds of it is spent. A check should then be drawn for the exact amount to bring the fund back to the original amount, listing on the check stub a summary of items for which the amount was spent.

Proper record keeping is a protection for you against dishonesty and it is your help against errors.

This is the third article in a series being prepared for Michigan Medicine *by representatives of the Lansing office, Professional Management Associates.*

In memoriam

Doctor Carstens

Henry R. Carstens, MD
Bloomfield Hills

Henry Rohnert Carstens, MD, former president, Council chairman and speaker of the house for MSMS, died Feb. 5 at the age of 84.

Doctor Carstens also had been director of the Veterans Administration's third region which included five VA hospitals in Pennsylvania, New Jersey and Delaware, and had served with the VA in other parts of the eastern U.S.

Dr. Carstens began his medical career in 1911 when he served with Gen. John Pershing's expedition to Mexico. He served in both world wars and was awarded the Legion of Merit and Crown of Italy in the second.

A graduate of Wayne State University College of Medicine and an internist, Doctor Carstens served as MSMS president in 1941-42; speaker in 1928 and chairman of The Council in 1939-40.

He also was president of the WSU Medical Alumni Association, the Detroit Academy of Medicine, Wayne County Medical Society and Michigan Medical Service.

Doctor Carstens had served as instructor at Wayne State University College of Medicine; chief, Department of Medicine, Crittenton General Hospital; medical director, Detroit Life Insurance Co., physician, Detroit House of Correction. He was a diplomate of the American Board of Internal Medicine, and fellow of the American College of Physicians and a member of its board of governors.

Carl E. Badgley, MD
Venice, Fla.

Carl E. Badgley, MD, head of orthopedic surgery at the University of Michigan Hospital for 29 years until 1961, died Feb. 4 in Venice, Fla. He was 79.

The recipient of numerous professional honors both in the U.S. and abroad, Doctor Badgley became an international figure in the teaching and practice of orthopedic surgery. A native of Dunkirk, N.Y., he earned his MD degree at the U-M.

(Continued on page 258)

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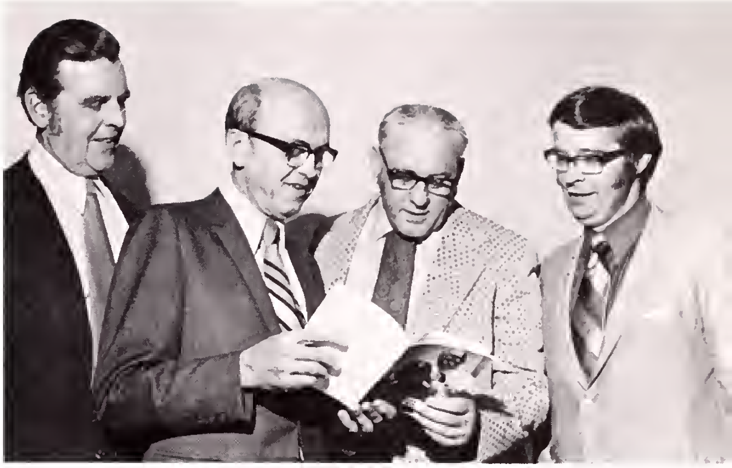

Michigan will play host to the 1974 National Conference on Rural Health, sponsored by the AMA. To further plans, key Michigan persons met at MSMS headquarters recently with Bond L. Bible, PhD, second from left, of the AMA Department of Rural Health. From left are John A. Doherty, executive vice president, Michigan Health Council; Doctor Bible; Robert E. Rice, MD, Greenville, and Donald L. McCorvie, MD, chairman, MSMS Commitee of Rural Medical Service.

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In 1932, Doctor Badgley was appointed head of orthopedic surgery at U-M, a post he held until 1961. He continued as a professor for two more years and finally retired from private practice in 1967.

Doctor Badgley was former Governor of the American College of Surgeons and was president of the American Academy of Orthopedic Surgeons in 1942-43. His former students established a lectureship at the U-M in his name on his retirement.

Samuel Freid, MD
Southfield

Retired Detroit-area physician Samuel Freid, MD, died Jan. 18 at the age of 63.

A native of Arnprior, Canada, he was graduated in 1935 from Wayne State University School of Medicine. He practiced 10 years in Saginaw before moving to the Detroit area.

Doctor Freid was a member of the American Academy of Family Physicians.

Russel R. Nykamp, MD
Zeeland

Russel R. Nykamp, MD, Zeeland physician from 1939 until 1967 when he retired, died Jan. 14 at the age of 68. Doctor Nykamp was on the staffs of Zeeland and Holland hospitals and was a native of the Holland area.

Dean W. Seger, MD
Lake City

Lake City family physician Dean W. Seger, MD, died Jan. 2 at the age of 50.

Doctor Seger was medical examiner for Missaukee County at the time of his death, and had served as county coroner for eight years previously. He also was medical examiner for the Federal Aviation Agency and was a former chief of staff one year at Mercy Hospital in Cadillac. Doctor Seger had been active with the Wexford-Missaukee chapter, American Red Cross and other civic groups.

A graduate of the University of Michigan Medical School, he was a member of the American Academy of Family Physicians, and the American Society of Anesthesiologists, Inc.

John F. Simpson, MD
Ann Arbor

The chief of the University Hospital Outpatient Neurology Clinic at Ann Arbor, John F. Simpson, MD, died Jan. 25 as a result of traffic accident injuries sustained near Toronto, Ontario.

Dr. Simpson, 44, was an associate professor of neurology at the U-M and served as a consultant to the Ann Arbor VA Hospital and Wayne County General Hospital. He also was a member of the U-M faculty Senate Assembly and was active in major medical center administrative committees.

Doctor Simpson was a graduate of the University of Wisconsin Medical School. He joined the U-M Medical School department of neurology in 1962. He was certified by the American Board of Psychiatry and Neurology and was a fellow of the American College of Physicians and the American Academy of Neurology.

He was a member of the Washtenaw County Medical Society's Highway Safety Committee and served on the Michigan Secretary of State's Medical Evaluation and Advisory Committee.

Stanley A. Stealy, MD
Grayling

Long-time Grayling physician Stanley A. Stealy, MD, died Jan. 16 at the age of 85.

Doctor Stealy was a graduate of the Wayne State University School of Medicine and had practiced in Grayling from 1935 to 1962, when he retired. Previously, he had practiced nearly 15 years in Charlotte and also served with the state health department in Rogers City.

He was a past president of the Eaton County and North Central Counties medical societies and had served as a delegate to MSMS from both.

Harold A. St. John, MD
Sun City, Ariz.

Former Pontiac physician Harold A. St. John, MD, died Jan. 2 at the age of 75. He had practiced 50 years in Pontiac, where he had been chief of staff at Pontiac General Hospital.

In 1971, Doctor St. John received the MSMS 50-year award in Annual Session ceremonies in Detroit.

SMS works to solve
malpractice problems

Michigan Medicine presents the following report of current and recent activities of the Michigan State Medical Society to correct the present professional liability insurance conditions. This is the fourth in this new 1973 series of featured articles about subjects of current concern to MSMS and Michigan doctors of medicine.

MSMS Works in Many Areas to Resolve Professional Insurance Situation

By Herbert A. Auer, Manager
Dept. of Communications

MSMS is continuing efforts to seek relief for Michigan physicians from the worsening professional liability insurance situation.

Solution of the malpractice problem is a top priority item for the MSMS House, MSMS Council, several MSMS committees, and also for other related medical organizations.

Malpractice insurance and suits have become a very important aspect in the delivery of medical care in Michigan. The premiums for professional liability insurance increased in Michigan over 100% from 1967 to 1971, according to information reviewed by the MSMS Bureau of Economic Information.

According to figures from the Michigan State Insurance Bureau the Class 5 premium in 1965 was $544 in Area 1. Today that premium in Detroit is $3,172. Class 5 includes the doctors in specialties most vulnerable to malpractice suits.

Physicians generally agree that "no one wants to see medical malpractice go unpunished but no one wants the constant threat of malpractice claims where no malpractice exists." This observation was made in a recent issue of *Michigan Medicine* by Perry W. Greene, Jr., MD, president-elect of the Kent County Medical Society and a member of the MSMS Legal Affairs Committee.

* * *

What was latest action by MSMS Council?

The MSMS Council on March 21 voted to investigate the possibilities of a self-insured professional liability insurance program. MSMS Council Chairman Robert M. Leitch, MD, has appointed an ad hoc study committee.

The Council also voted March 21 to suport the introduction of bills that would (1) require a certificate of merit by the plaintiff within a fixed time after filing a complaint, (2) clearly define malpractice, (3) ban medical literature of any kind as evidence in a malpractice action, and (4) amend the statute fraud to require written agreements as the sign of warranty. Thomas R. Berglund, MD, chairman of the MSMS Committee on Legal Affairs, reported to the Council that the Legislative Study Committee on Medical and Hospital Malpractice Problems "will consider these four proposals and seek introduction of some kind of malpractice legislation this spring." The recommendation that the MSMS Council support these four ideas was made by the Legal Affairs Committee.

* * *

What other possible solutions are there?

Following are some of the other possible malpractice courses that have been discussed and are under review by various MSMS committees or medical groups in Michigan.

Should legislation be introduced, as in Indiana, to require a plaintiff to post bond in medical liability suits with provisions for forfeiture?

Should MSMS promote a bill to establish an arbitration program as used in some states with physicians and attorneys serving on joint arbitration panels?

Should MSMS buy a malpractice insurance company and then operate its own group plan?

Should MSMS members establish their own malpractice fund and pay claims from the fund, and thus discontinue insurance payments by individual physicians?

Should MSMS propose that medical malpractice suits be taken out of the courts and handled as workman's compensation cases are now?

Should MSMS develop a possible bill patterned after the AMA model professional liability act?

Should MSMS work to change laws to obtain a more certain statute of limitations?

Should MSMS propose a program like New York's where a review panel determines if a suit is warranted?

* * *

What is status of legislative study?

The Legislative Study Committee on Malpractice Actions and Professional Liability in Medicine was created by Senate Concurrent Resolution #28 adopted in 1971.

The resolution created a committee comprised of six state senators and six representatives "to study medical professional liability insurance and premiums, to seek solutions that will assure security to patients and freedom for physicians to function, and to report its findings and recommendations to the Legislature." The resolution also authorized the appointment of a 15-member Citizens Advisory Committee.

The Michigan legislative resolution, in creating the study committees, noted that "the risk of malpractice suits can cause physicians to request additional laboratory and X-ray studies as a precaution against potential law suits, thus directly increasing the cost of care to patients."

MSMS supported the resolution which in part declared that "organized medicine recognizes the right of the patient to sue where there is justifiable belief that a medical procedure has been faulty or a physician negligent, but contends that physicians must be afforded protection from frivolous, malicious or punitive suits purely for pecuniary gain."

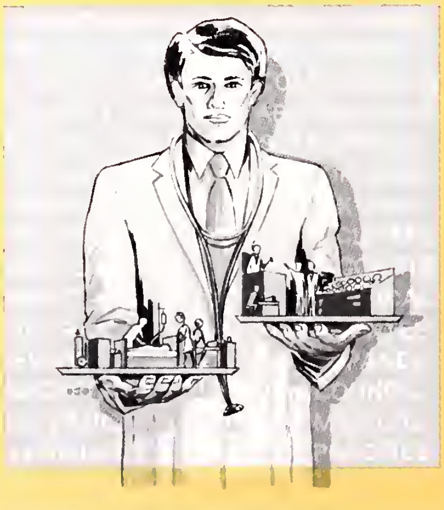
The MDs on the Citizens Advisory Committee are Fredrick Weissman, MD, Detroit and Ophelia Baker, MD, now of Saginaw.

The chairman of the 12-member Legislative Committee, chosen by the group, is L. Harvey Lodge, senator from Oakland County. A resolution to extend the study into the current session of the Legislature is pending.

* * *

What action did 1972 MSMS House take?

Resolution 30 was adopted by the MSMS House of Delegates last fall which resolved: "That MSMS encourage legislative action toward requiring the posting of a suitable security cash deposit or bond as security for the payment by the plaintiff of all costs and reasonable attorney fees incurred by the defendant in defending the action, if the plaintiff fails to recover any damages, similar to legislation recently passed in California."



The resolution, which was introduced by Richard A. Rasmussen, MD, Grand Rapids, also instructed the MSMS delegates to the AMA "to encourage similar legislation in all other states."

The MSMS delegation, chaired by Donald N. Sweeny, Jr., MD, introduced such a resolution at the AMA House of Delegates in November in Cincinnati.

The AMA House accepted the intent of the resolution but referred the matter to the AMA Board of Trustees for study and appropriate action.

Doctor Sweeny, in discussing the AMA House action, told The MSMS Council that the California law referred to in the MSMS resolution "provides for the filing of bonds in two instances: (1) related to a bond to secure court costs only, and (2) including security to cover costs and reasonable attorney's fees, in that element of the plaintiff's suit seeking punitive damages. The latter amendment has not become operative and is under consideration of the court as to its constitutionality."

* * *

Could MSMS sponsor malpractice insurance?

In an effort to develop a MSMS group malpractice insurance program, The MSMS Council in 1971 authorized the firm of Johnson and Higgins to investigate and report back. (The Johnson and Higgins firm had attracted considerable interest because it had successfully put together the group program for Los Angeles County Medical Society).

Colton Scarborough appeared before The MSMS Council August 4, 1972 and reported that the proposed MSMS group plan objectives were reviewed with 10 firms. Johnson and Higgins representatives traveled to New York, Hartford, Los Angeles and Detroit to negotiate "with top level management of interested firms."

Mr. Scarborough explained to The MSMS Council that his firm had not been able to develop a MSMS proposal primarily because rates suggested by interested firms were all higher than the Medical Protective Company of Fort Wayne, Ind. (Medical Protective insures about 70% of Michigan physicians, who carry professional liability insurance.)

The Johnson and Higgins firm offered and the Council accepted "to continue its marketing activities on behalf of MSMS."

The firm explained "that our biggest problem in negotiating for a Michigan plan is the lack of valid statistical data on premiums and claims for Michigan physicians whether insured by Medical Protective, companies participating in the national Insurance Service Office, Lloyds or others."

The Council voted to conduct a research project in order to build an experience file that would be helpful in future negotiations toward a sponsored plan.

(Editor's Note: The results of the recent MSMS survey to obtain such information appear on Page 262 of this issue of **Michigan Medicine.***)*

* * *

What is Specialty Council considering?

Possible approaches to the malpractice situation are being studies by the Michigan Council of Medical Specialty Societies, a new organization fostered by MSMS which meets monthly. Each specialty society has one delegate to The Council

The Specialty Council, as part of its study, heard on Jan. 31 progress reports about MSMS efforts from Robert M. Leitch, MD, Council chairman, and Robert M. Stow, MD, councilor and former chairman of the MSMS Committee on Professional Insurance Plans.

Council Moderator Glenn E. Moore, MD, Flint, appointed Arthur J. Johnson, MD, Detroit, representative of the Detroit Branch of the American Urological Society, to develop a proposal.

Establishment of a merit-panel system has been reopened by Doctor Johnson. He suggests that such a panel include three representatives from each medical specialty to review malpractice cases. These panel members would study the malpractice cases and develop an evaluation which would be available to the court for either the defense or the plaintiff.

* * *

How about no-fault malpractice insurance?

In 1971, the MSMS House of Delegates adopted Resolution 16 which authorized MSMS "to investigate the feasibility of a no-fault malpractice insurance system." Author of the resolution, D. Bonta Hiscoe, MD, Lansing, observed that "the current adversary system is badly over-used and abused."

The concept was proposed by MSMS at a series of meetings between medical and osteopathic physicians, and to a special malpractice committee.

The MSMS House in the fall of 1972 received a progress report on the implementation of Resolution #16 and was told that "no definite program for malpractice insurance really has developed."

* * *

Would Workmen's Comp. idea work?

The proposal that a system like that used for state Workman's Compensation cases be developed to replace the court-handled malpractice cases recently was advanced by John W. Moses, MD, editor of the *Detroit Medical News* published by the Wayne County Medical Society.

Instead of paying for insurance, Doctor Moses proposes that every doctor pay a specific amount into a state pool to pay any settlements awarded by a state board. The doctor who had a claim settled against him would pay a higher contribution when his renewal came up.

Through this change, Doctor Moses believes "here would be a way to recompense a patient for an untoward occurrence without ruining everybody in the process."

* * *

Is AMA considering a group policy?

Recently the MSMS Committee on Professional Insurance Plans conferred with Howard F. Snevel, Jr., of the AMA Membership and Insurance Benefits Department. He pointed out that the AMA has been unable to offer a group malpractice policy because any sponsoring firm would want 60% of the total membership to participate.

* * *

What did recent HEW study find out?

Recently a special national "HEW Commission on Malpractice" concluded 16 months of study. Findings of the Commission were not unanimous and no single solution was recommended.

Instead the Commission suggested that a variety of ways be explored to modify malpractice laws at the state level.

AMA President Carl A. Hoffman, MD, a member of the Commission, submitted to the Commission some 40 pages of comments that deal with what the AMA has described as "shortcomings contained in the report."

Doctor Hoffman, in his dissenting report, declared, "The report gives the false impression that the rapid increase in the frequency and cost of claims has arisen from a deterioration in the general quality of health care. The reality is the frightening paradox that the general quality of health care has been improving dramatically at the same time that the frequency and cost of claims have been skyrocketing."

The HEW Commission recommended:

- All health care institutions be required to establish patient grievance machinery;
- A system for graduated scale of contingency fees be developed;
- Methods be found to encourage wider use of arbitration to resolve disputes;
- State legislatures be encouraged to alter rules of liability, procedures and evidence.

The Commission report is strictly advisory and the HEW secretary is not required to make any legislative proposals on the basis of any content.

*(Editor's Note: **The American Medical News** for Feb. 5, 1973 carried highlights of the report and portions of Doctor Hoffman's critique.)*

* * *

Will PSRO have an effect on malpractice?

Some authorities on medical care have predicted that the new PSRO law will have considerable effect on malpractice. The PSRO law will provide for the imposition on physicians and hospitals of "norms of care, diagnosis and treatment" based on "typical patterns of practice" in the PSRO areas. By carefully adhering to such standards physicians may have good defense against any alleged malpractice. In the past some plaintiff's attorneys have had difficulty establishing what constitutes standards of care. That would no longer be true, assuming that the PSRO developed norms are admissible in court as acceptable standards.

MSMS Econ Bureau Releases Survey Info Re Insurance, Suits

By John Anthony
Chief, Bureau of Economic Information

Early in 1973, the MSMS Bureau of Economic Information conducted a research project among MSMS members regarding malpractice insurance and suits.

This was done at the request of the MSMS Council to obtain an experience file that would be helpful in possible future negotiations toward a MSMS-sponsored group malpractice insurance program. The firm of Johnson and Higgins, which is continuing its exploration of a possible plan for MSMS, had requested such an indepth survey.

The questionnaire was sent to all members in an issue of the MSMS *Medigram*. There were over 1,500 replies which have been tabulated by the MSMS Bureau of Economic Information. The survey asked for information about the type of practice, limits of liability coverage, insurance carrier, annual premiums, excess liability coverage claims and suits. There are approximately 6,000 MDs in Michigan with professional liability insurance. The number of questionnaires completed and returned to MSMS headquarters was 1,586. Of these 24 reported no insurance coverage, and 99 were unusable for various reasons.

An analysis of the responses revealed the following about those physicians who participated in this survey.

1. Almost all of those responding (1,463 or 98.4%) are covered by professional liability insurance.

2. The Medical Protective Company insures 70.4% of those who identified their carrier. The Shelby Mutual Company insures 11.1%, St. Paul insures 5.2%, and Aetna insures 3.6%. All other carriers cover the remaining 9.7%.

3. Most physicians (97.0%) have base coverage of \$100,000/\$300,000 or higher. 33.8% have a base coverage of \$200,000/\$600,000 or higher. The percent of individuals with this amount (\$100,000/\$300,000 or higher) of a base coverage has increased 5.5% since a similar MSMS study conducted in 1970.

4. Over half (52.5%) had yearly premium costs of over \$1,000. Almost one fourth (23.8%) had yearly premiums over \$2,000. And 6.7% had costs over \$3,000 yearly.

5. Of those covered by liability insurance, 846 or 57.8% also carried excess or "umbrella type" liability coverage. Most were for \$1,000,000; however, 66 individuals had \$2,000,000 coverage or higher. This represents a 14% increase in those who have excess liability coverage from the 1970 study.

6. Of those responding, 34.9% indicated they were in Class 1, 12.7% were in Class 2, 9.4% were in Class 3, 18.9% were in Class 4, and 24.1% in Class 5. These standardized classifications categorize doctors according to their fields of practice.

7. In Area 1 (Wayne, Oakland, and Genesee Counties) 35.9% were in Class 4 or 5. In Area 2, the balance of the state, 48.5% were in Class 4 or 5. This can be explained, in part, since there are more generalists performing surgery in this area versus the Wayne, Oakland, and Genesee area. The generalists in outstate Michigan who are needed to perform more surgery are thus placed in a more costly classification for liability insurance.

8. There were 159 incidents of claims reported by the 1,463 respondents for the five-year period since January 1, 1968. Eighty-five of these were reported in Area 1 (Wayne, Oakland, and Genesee Counties), with the other 74 cases in Area 2. Area 1 had 53.5% of the incidents; however, they only comprised 42.4% (621 of 1,463) of the total respondents. There are more suits per physicians in the three-county metropolitan area.

9. Of the 159 suits, 110 are currently open, and 49 have been closed. Of those closed, 40 were settled out of court. The average settlement was \$6,729. Nine were decided in court. Of those nine that involved litigation, eight were decided in favor of the physician and one in favor of the plaintiff. The one case that was settled in court involved a settlement of \$12,000.

President's page

John J. Coury, MD
MSMS President

"Doctor Coury, your general pep talk about getting involved sounds good, but specifically what can one member do?"

I've heard that question more than once in response to these monthly messages in *Michigan Medicine.* And I've faced that question after talks to component medical societies.

So . . . let me be specific. Here's what one physician can do . . .

Attend all meetings of your county society to keep informed on current events and developments. Exercise your right to a voice in the affairs and activities of medical organization.

Give your local society officers and committee chairmen real cooperation. They are key men in the activities of organized medicine.

Send to the MSMS office your suggestions on how the activities of MSMS can be improved.

Promote the work of your local society, MSMS and the AMA by telling your patients, friends and acquaintances about their activities.

Assist in the public relations programs of your local and state societies by holding the confidence and respect of your patients. By practicing ethically, rendering good medical service and winning the confidence of his patients, the individual physician becomes a builder of good public relations for the entire medical profession.

Keep the MSMS office posted on events and developments in your community.

Answer every questionnaire received from your state association promptly and completely. MSMS is effectively using surveys more than ever before.

Support through your attendance and interest the conferences sponsored by MSMS. And plan now to participate in the 1973 Annual Session.

Read Michigan Medicine and *Medigram* regularly so you will know what MSMS is doing and how you can promote and support its programs. And read the *AMA Medical News.*

Accept appointments to committees and other assignments as a responsibility and carry out the responsibility to the best of your ability.

Remit your annual dues promptly to your local secretary-treasurer. Neither your local society nor your state association can carry on necessary activities unless they are adequately financed.

Join MDPAC. Do this so you will have a voice in helping to elect capable and informed people to state and national offices. The quality of our laws is determined by the quality of our lawmakers.

And in closing, let me appeal to each of you to take an active interest in the affairs of your county medical society. The county societies are the keystones of your state and national societies.

Your local and state societies will be just as effective, active and alert as their individual members. You will get out of them what you put into them.

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Everybody experiences psychic tension.

Most people can handle this tension.

Some people develop excessive psychic tension and need your counseling

and a few may need counseling
and the psychotropic action of Valium® (diazepam).

Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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Valium®
(diazepam)

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

Small doses

Craig E. Booher, MD, Grand Rapids,
is new assistant dean for continuing education at Rockford School of Medicine, Rockford, Ill. Doctor Booher resigned Feb. 1 as director of medical education at Blodgett Memorial Hospital, and as president of the Grand Rapids Area Medical Education Center.

Thomas J. Cinque, MD, East Lansing,
is director of undergraduate medical education for Saginaw Cooperative Hospitals, Inc., formed in 1969 to manage medical education programs in Saginaw in cooperation with MSU College of Human Medicine. Doctor Cinque, who succeeds Peter O. Ways, MD, is an associate professor of medicine with MSU.

John Heffelfinger, MD, Coldwater,
is 1973 Citizen of the Year in his community. Named by the Greater Coldwater Area Chamber of Commerce, Doctor Heffelfinger was singled out for his service as a pediatrician and as chief of staff of the Community Health Center of Branch County, for serving as an instructor for University of Michigan medical students, for service to the Coldwater State Home and Training School and on the Battle Creek Child Guidance and Adult Clinic Board of Directors.

C. L. Hodge, MD, Reading,
was honored by his community recently with presentation of a special outstanding service award. Doctor Hodge has served 42 years as family physician in Reading.

Margaret Jones, MD, East Lansing,
is new president of the Mid-Michigan Society for Instructional Technology. Doctor Jones is a neuropathologist on the faculty at Michigan State University. The Michigan Society for Instructional Technology is a unit of the National Society for Programmed Instruction.

Richard Klein, MD, Royal Oak,
is one of five Outstanding Young Men named by the Michigan Jaycees in mid-February. Doctor Klein, president of the South Oakland Unit of the Michigan Cancer Foundation, won recognition for his work in oral cancer.

Walter D. Meester, MD, Grand Rapids,
is a new member of the six-member State Scientific Commission for Controlled Substances. He is affiliated with Grand Rapids' Project Rehab for drug addicts.

(Continued on page 271)

acute arthritic inflammation...heat that freezes

In acute rheumatoid arthritis consider Tandearil. The anti-inflammatory action of Tandearil quickly helps reduce heat, pain, swelling, and stiffness. Results are usually seen in 3 or 4 days. Try it for a week when the symptoms defy aspirin control.

Remember that Tandearil is not a simple analgesic. It should not be used on patients responding to routine therapy. Before using, please read the prescribing information. It's summarized below.

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Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.
Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.
Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.
Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.
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No sleep medication has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia patients given one 30-mg capsule of Dalmane (flurazepam HCl) at bedtime, on average: fell asleep within 17 minutes, had fewer nighttime awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to repeat dosage during the night.

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Over multiple nights of therapy, no waning of drug effectiveness was noted. There was consequently no need to increase dosage during the study periods. It stands to reason that the fewer repeat or incremental doses needed to sustain sleep, the lower the total cost of the sleep medication. Consistent effectiveness is the measure of Dalmane (flurazepam HCl) economy.

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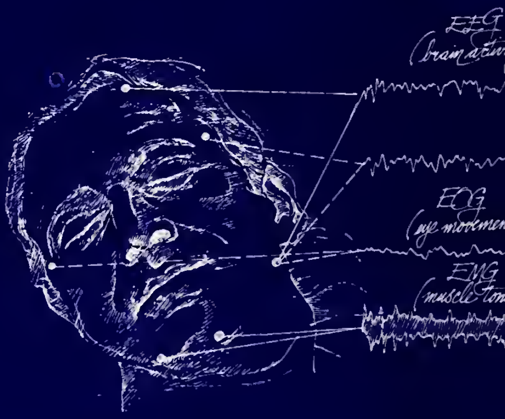

One 30-mg capsule *h.s.*—usual adult dosage.
One 15-mg capsule *h.s.*—initial dosage
for elderly or debilitated patients.

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Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psycholog
dependence have not been reported c
recommended doses, use caution in a
ministering to addiction-prone indivic
or those who might increase dosage.

Precautions: In elderly and debilitate
initial dosage should be limited to 15 r
to preclude oversedation, dizziness a
or ataxia. If combined with other drug
having hypnotic or CNS-depressant
effects, consider potential additive eff
Employ usual precautions in patient
who are severely depressed, or with

depression or suicidal tendencies
lic blood counts and liver and kid-
nction tests are advised during
ed therapy. Observe usual precau-
n presence of impaired renal or
c function.
se Reactions: Dizziness, drowsi-
ghtheadedness, staggering, ataxia
lling have occurred, particularly
rly or debilitated patients. Severe
on, lethargy, disorientation and
probably indicative of drug intoler-
r overdosage, have been reported.

Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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C. Allen Payne, MD, Grand Rapids,
is beginning a new three-year term as a director of the Greater Grand Rapids Chamber of Commerce.

John C. Peirce, MD, Grand Rapids,
is new chairman of the Michigan Kidney Foundation's Scientific Advisory Board.

Homer Ramsdell, MD, Manistee,
was recipient on Feb. 24 of the Manistee News Advocate's "Good Guy" award. Nominated by patients and friends, the doctor has practiced in Manistee for nearly 60 years.

Maurice S. Reizen, MD, Okemos,
director of the Michigan Department of Public Health, and George W. Slagle, MD, Battle Creek internist, are new members of the Michigan Association for Regional Medical Programs.

Ronald W. Richards, PhD, East Lansing,
is new director of the Office of Medical Education Research and Development at Michigan State University. He has served as acting director since July. OMERAD focuses the joint efforts of physicians, educators and psychologists on new approaches to the instruction of medical students.

Thomas E. Finch, MD, Traverse City,
is new national treasurer for 1973 of the Development Fund Board of Central Michigan University. He has been national director of the board since 1969 and is co-chairman of the University's Traverse City alumni chapter.

John J. Voorhees, MD, Ann Arbor,
associate professor of dermatology at the University of Michigan Medical School, is the 1973 recipient of the U-M's Russel Award. Doctor Voorhees is recognized as a young faculty member showing scholarly achievement and promise. Doctor Voorhees is currently directing an internationally recognized research project into the molecular basis for psoriasis.

Robert Douglass, MD, Farmington,
is "Citizen of the Year" in his community, so named by the Farmington Chamber of Commerce in recognition of his work as a physician and community leader. Doctor Douglass is director of the WSU thyroid service, is founder of the Farmington Area Naturalists and has been a board member of the Farmington Area Advisory Council since 1971.

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Methyltestosterone N.F. -25 mg.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en 3-one.

ACTIONS Methyltestosterone is an oil soluble androgenic hormone.

INDICATIONS In the male 1 Eunuchoidism and eunuchism 2 Male climacteric symptoms when these are secondary to androgen deficiency 3 Impotence due to androgenic deficiency 4. Postpuberal cryptorchidism with evidence of hypogonadism
Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone These changes appear to be related to dosage of the drug Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

PRECAUTIONS Prolonged dosage of androgen may result in sodium and fluid retention This may present a problem, especially in patients with compromised cardiac reserve or renal disease In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

CONTRAINDICATIONS: Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast Contraindicated in the presence of severe liver damage

WARNINGS: If priapism or other signs of excessive sexual stimulation develop, discontinue therapy In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens Hypercalcemia may occur, particularly during therapy for metastic breast carcinoma. If this occurs, the drug should be discontinued.

ADVERSE REACTIONS: Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastic breast carcinoma This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

DOSAGE AND ADMINISTRATION: Dosage must be stricly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as an average daily dosage guide.

INDICATION	Average Daily Dosage Tablets
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Transection of the trachea: *problems in diagnosis and management*

By John R. Kirkpatrick, MD
Norman W. Thoms, MD
M.A. Ali, MD
Detroit

Traumatic tracheal injuries are not common. Most have occurred as a result of penetrating wounds of the neck although reports have appeared in the literature[1,2,3] documenting blunt trauma as the causative agent. The severity of the injury has ranged from minor puncture wounds to complete transections. The rarest of these has been a complete transection from blunt trauma.

Case Report

D. G. (#767566) a 56-year old black male was involved in a one car accident. He was not wearing safety restraints at the time of his injury. Following the accident he was brought directly to the Detroit General Hospital emergency department in severe respiratory distress. Other vital signs were normal. There was no apparent intra-abdominal injury. He was noted to have a strong odor of alcohol on his breath and responded only to painful stimuli. The severe respiratory distress was felt by the initial observer to be the result of a "flail" chest as evidenced by marked sternal retractions. Breath sounds were equal bilaterally and marked inspiratory stridor was noted. It was felt that assisted ventilation would be needed for control of the respiratory distress.

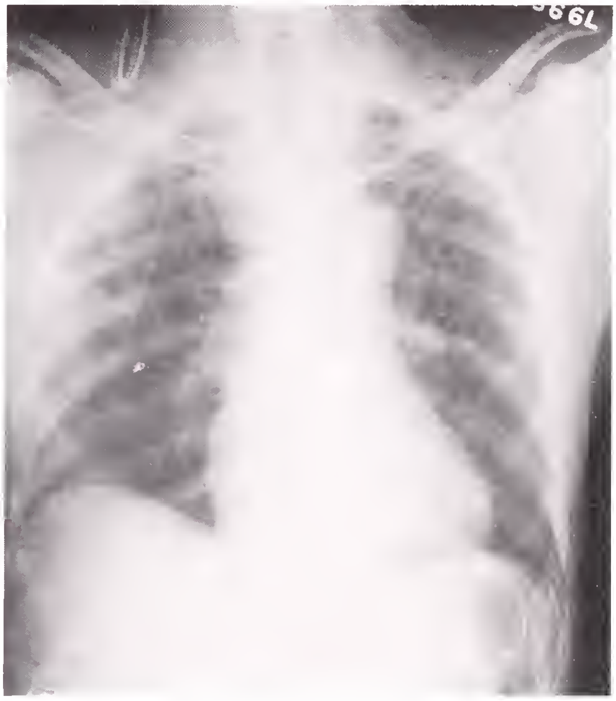
Figure 1. Admission chest film. Note the subcutaneous air in the lower neck.

Following chest x-ray he was taken to the operating room for tracheostomy. The chest x-ray (Fig. 1) revealed minimal subcutaneous emphysema over the lower neck which had not been apparent clinically. In the operating room an endotracheal tube was inserted. Insertion of this tube and ventilation with positive pressure produced massive subcutaneous emphysema of the neck followed immediately by a respiratory arrest. Emergency neck exploration was performed revealing a complete transection of the cervical trachea at the second ring. The endotracheal tube was protruding from the proximal line of transection. The distal portion of the trachea had retracted to a retrosternal position and immediate ventilation was possible only by inserting an endotracheal tube through the neck incision into the distal portion of the trachea. The distal segment was mobilized by blunt dissection so that the avulsed ends of the trachea could be reapproximated. It was apparent

Scientific articles

The authors are with the Department of Surgery, Wayne State University School of Medicine, and Detroit General Hospital. Their paper is supported by the Detroit General Hospital Research Corporation.

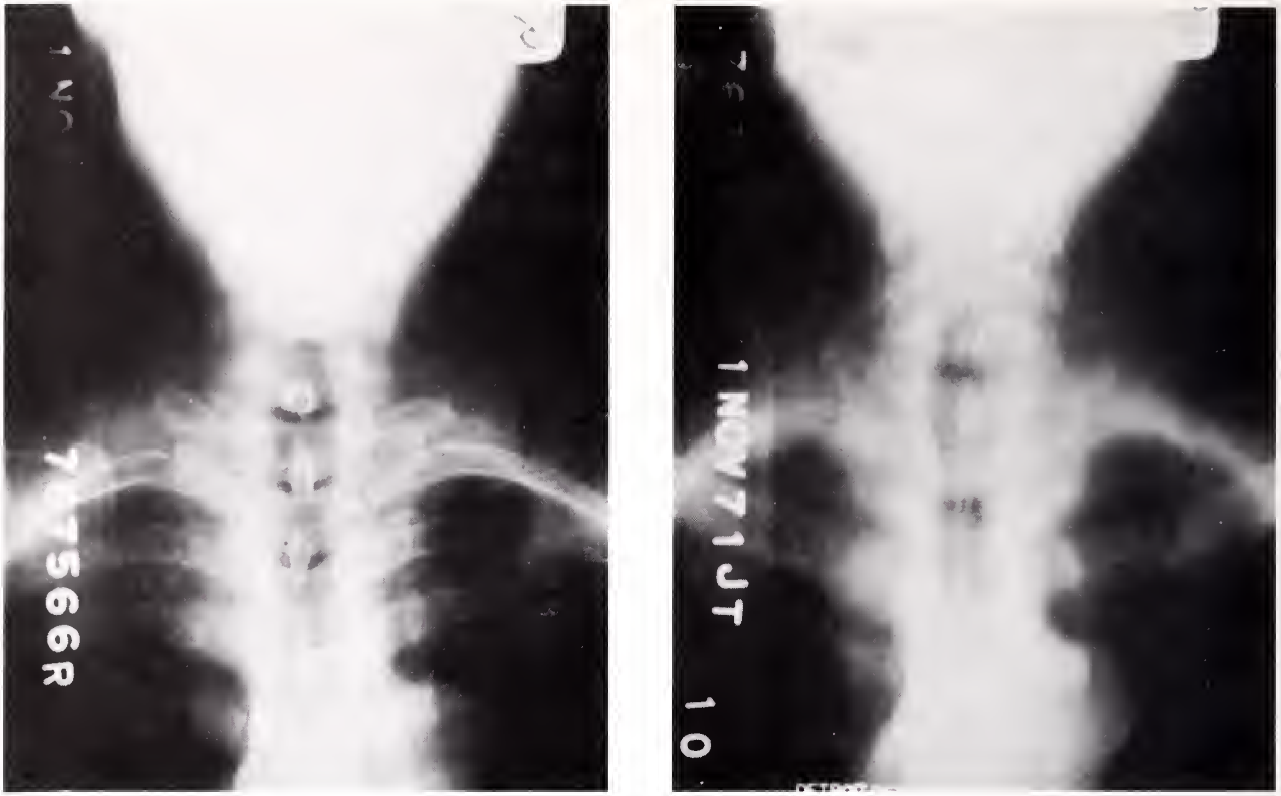

Figure 2. Cervical laminograms. a) This posterior view reveals no evidence of tracheal stenosis. b) Superficial anterior view demonstrates marked narrowing of the trachea.

at this time that moderate suture line tension would result if a primary anastomosis was performed. A tear in the esophagus at the level of the tracheal avulsion was noted and repaired with several interrupted sutures.

Prior to performing a tracheal anastomosis, we tried unsuccessfully to identify the recurrent laryngeal nerves. We then anastomosed the trachea end-to-end with interrupted sutures joining the posterior and lateral walls of the trachea. A small opening was left anteriorly to be utilized as a tracheostomy stoma. This anterior opening was sutured to the skin.

The patient's postoperative course was complicated only by the development of a small pneumothorax presumed to be a result of the neck exploration. The tracheostomy tube and skin sutures were removed on the seventh postoperative day. He was discharged on the 12th day without any evidence of airway obstruction.

He was readmitted to the hospital one month later because of persistent inspiratory and expiratory stridor, hoarseness, and failure of his tracheostomy stoma to heal satisfactorily. Cervical laminographs were obtained **(Fig. 2)**. There was no evidence of tracheal stenosis posteriorly, although anterior narrowing at the area of the stoma was noted. Through the bronchoscope we observed that there was no circumferential stenosis but that the trachea was partially obstructed by exuberant granulation tissue protruding from the tracheostomy site. This acted as a ball-valve mechanism and produced his symptoms. The prominent tracheostomy scar and granulation tissue were excised and the small anterior defect in the trachea was closed with several interrupted non-absorbable sutures. He did well following this procedure and except for slight hoarseness, he is asymptomatic and has returned to work.

Discussion

This case illustrates many of the problems encountered in establishing a diagnosis of transection of the cervical trachea. A variety of findings have been reported in patients with this injury including subcutaneous emphysema, a shift in tracheal position, contusions over the site of injury and respiratory stridor. It should be emphasized that some or all of these findings may be absent, especially in those cases resulting from blunt trauma. Lack of sufficient symptoms to establish a diagnosis has not been a problem in injuries from penetrating wounds.

There is no assurance with this injury that the surgeon can reach a correct diagnosis based upon precise symptomatology. The physician who first sees the patient must be aware that this type of injury can occur and must appreciate the suddeness with which a relatively stable situation can deteriorate to the point of a respiratory arrest. It is of particular interest that our patient's respiratory arrest was associated with the insertion of an endotracheal tube and assisted positive pressure ventilation. This has not been previously reported. It is not known whether this represents a common occurrence or an isolated event. In retrospect one should certainly consider the possibility of a tracheal transection whenever this sequence of events occurs.

Inspiratory stridor was the hallmark of the tracheal transection in our case. The resulting inspiratory chest wall retraction was interpreted as a flail chest by an advanced surgical resident experienced in evaluating patients with chest trauma. His confusion on this particular point illustrates the great difficulty in separating the various types of paradoxical respiration. The diagnosis of tracheal transection must therefore be made by carefully distinguishing sternal and chest wall retraction from the paradoxical movement of a flail chest.

Establishment of the diagnosis of tracheal transection necessitates some type of surgical intervention. The procedure chosen should both establish an airway and restore the normal anatomy of the trachea. Most authors have advocated primary repair as the best method to accomplish these goals. However, it should be stressed that certain situations exist where this approach is neither feasible nor desirable.

One of these situations occurs when the surgeon is not able to satisfactorily assess the function of the vocal cords or identify the recurrent laryngeal nerves. In this situation primary repair is hazardous since nonfunctioning vocal cords can result in an obstructed airway following removal of the endotracheal tube. For this reason advocates of primary repair have emphasized the need for performing a tracheostomy distal to the anastomosis. This type of tracheostomy would not be satisfactory for long-term care if nonfunction of the vocal cords was discovered postoperatively.

A second situation where primary repair is usually not desirable occurs when the transection is below the level of the second ring. When this situation exists, it is exceedingly difficult to perform a distal tracheostomy without either splitting the sternum or placing the stoma so near the anastomotic line that vascular compromise results. Avoidance of a median sternotomy on an emergency basis is highly desirable; thus, inability to perform a tracheostomy without sternotomy should represent a relative contraindiction to primary repair.

A third situation where a primary repair is not ideal occurs when excessive suture-line tension is anticipated. The degree of retraction of the transected portion of the trachea can be quite dramatic. As in our case, it is not unusual for the distal remnant to be found in a retrosternal location. It is possible by blunt finger dissection to free this portion of trachea sufficiently to allow reduction into the neck. However, following this maneuver, excessive tension may be present. Unless this tension is satisfactorily eliminated, stenosis and failure is almost assured.

The operative procedure performed in our patient represents a compromise with the ideal, necessitated by the situations described above. Primary anastomosis involving approximately three-fourths of the trachea re-establishes normal tracheal architecture and provides a small anterior opening which can be utilized for the tracheostomy stoma. If necessary, it is possible to relieve any anastomotic tension by approximating this stoma to the skin. Following removal of the tracheostomy tube, a trial at secondary healing can be attempted. In our patient this resulted in the formation of a soft issue valve. However, it should be emphasized that correction of this type of soft tissue defect is quite simple and involves only excision of the scar and closure of the small anterior defect.

We recommend that patients with tracheal transections have primary surgical repairs. Three situations, however, should modify the surgeon's approach to this injury: inabililty to satisfactorily assess the function of the vocal cords, inability to perform a distal tracheostomy, or undue tension on the suture line necessitates staging of the repair. It is suggested that the technique outlined in this report represents an acceptable alternate procedure when primary repair is not desirable.

Synopsis

A patient with a transection of the cervical trachea from blunt trauma was recently encountered at the Detroit General Hospital. The rarity of this lesion and obscurity of symptoms create real problems in the diagnosis and management of this injury. The injury may mimic a "flail" chest, and may be associated with acute airway obstruction. Therapy is directed towards the establishment of an airway and the restoration of normal tracheal anatomy.

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Perinatal tips

By Paul M. Zavell, MD
Detroit

The following case from the files of the Wayne County Medical Society Perinatal Mortality Committee is presented as an aid in continuing education.

Maternal

This was the sixth born of a Gravida VIII, Para V (VI) 38 year old white mother with A+ blood type. Two prior pregnancies had ended in spontaneous abortions. This pregnancy was essentially uncomplicated.

After 40 weeks, labor began and progressed so that after eight hours and 10 minutes a 10 pound, 5½ ounce male infant was born. He was blue at birth (this was thought due to anesthesia to mother. She was given Phenergan 25 mgm IM five hours and 50 minutes as well as Demerol 50 mgm and Scopolamine gr 1/200 four hours and 35 minutes before delivery.) The mother had gained 25 pounds during pregnancy.

Fetal

This 10 pound, 5½ ounce white male infant was noted to be blue with poor muscle tone after birth. The Apgar was 5 at one minute but was 10 at five minutes (after suction of naso-pharyngeal areas and emptying stomach of "several tablespoons" of amniotic fluid.)

The infant continued to do well thereafter and was seen daily by the pediatrician. At two days of age he was circumcized without difficulties. There was questionable jaundice noted on the third day of life.

At 3½ days of life the infant suddenly became pale and grunty with some spitting-up noted for the first time. A chest x-ray was done that showed slight increase in density of the lungs (suggesting an alveolar process perhaps due to aspiration). Heart was reported as completely normal. The impression was "very mild respiratory distress." No therapy was started except oxygen and mist.

By four days of age it was noted there was decreased breathing bilaterally with decreased breath sounds. The rectal temperature was 100° and the respiratory rate was 80/minute with 160 heart rate. Skin was mottled generally. The impression was 1) rule out T.E.F., 2) rule out metabolic defect and 3) rule out hyaline membrane. The infant was treated with oral glucose water and was started on aqueous crystaline penicillin 150,000 units IM q12h and Kantrex 35 mgm IM q12h. Studies done revealed hgb. of 20.6 gm. with 18,410 WBC's and a differential smear of two bands, 68 PMN's, 29 lymphs and one eosinophil. Bilirubin total was 2.6 mgm%. As the day continued the infant's condition seemed to worsen and he was transferred to NICU at another hospital.

At NICU he was noted to be very irritable with mild respiratory retractions, and liver 5-6 CM below R.C.M. An EKG showed "prolonged PR interval with notched and tall P waves suggesting atrial hypertrophy." Blood glucose was 72 with 11.1 mgm% calcium. A spinal tap was traumatic but did show xanthochromatic fluid. A chest x-ray showed "peribronchial infiltration bilaterally (suggesting aspiration) and border-line enlargement of the heart in the transverse diameter." The infant was digitalized using Digoxin 0.1 mgm IV stat and 0.05 mgm IM q8h. The impression now was "possible CHD and aspiration pneumonia."

As the day progressed his condition seemed to worsen with 160-200 heart rate, 100/minute respiratory rate and cyanosis in oxygen despite the therapy noted so that mercuhydrin 0.2 cc IM was given in addition. However, by the fifth day of life it was felt the cardiac condition had worsened. A pediatric cardiologist was called in. He confirmed the critical condition of the infant but after an EKG showed only relative RV dilatation he felt there was no true mechanical heart defect. A blood sugar showed 39.8 and IV glucose water was given. On the 6th day of life a generalized convulsion occurred followed by intermittent twitching of the right arm. A spinal tap was done again revealing xanthochromic fluid but normal protein, sugar. The infant was given Valium and Phenobarbital.

(Continued on page 282)

Doctor Zavell is chairman, Neo-Natal and Hospital Care Commitee, Michigan Chapter, A.A.P., and chairman, Perinatal Mortality Study Committee, Wayne County Medical Society.

Involvement of medicine residents in a drug treatment program - an educational experience

Robert B. Carbeck, MD
Ann Arbor

Introduction

In reviewing our graduate training program in internal medicine as it then existed, it became apparent that any experience provided in the medically important field of drug addiction was incidental. The importance of resident education in social, ambulatory and preventive medicine is now widely recognized. [1,2]

Being firmly convinced that an essential ingredient for any successful educational program is active trainee participation, we decided to explore the possibility of combining education with service through the ongoing participation of our medicine residents in a hard drug program. It was agreed that this involvement, consisting of examining all applicants for the program, would be conducted through the Academic Medicine Service.[3]

Our participation and experience in this program forms the basis for this paper.

Development

The Washtenaw County Community Mental Health Center began development of a hard drug program (HDP) approximately two years ago. The support requested from our medical staff consisted of a complete history and physical examination for each applicant averaging five to seven per week. The bulk of the history was self-administered and only required review by the physician, leaving the physical examination as the major portion of physician involvement. Some members of the medical staff were opposed to having the hospital involved with this type of patient, feeling that they might well interfere with the existing programs through thefts, attacks on hospital personnel, etc. These latter fears have not been realized after 18 months of participation.

Method

During the initial discussion with the directors of the Hard Drug Program, it was made clear that we expected educational, rather that pecuniary payment for our residents in return for their services. It was agreed that this obligation would be discharged through a series of joint seminars involving our resident staff and the drug program staff. Through this mechanism the medical residents would be able to follow the progress of the applicants that they personally had examined and, equally as important, would be able to learn more about the total drug program and its progress.

Results

The meetings were all joint seminars scheduled monthly and involving the medicine residents and the staff of the drug program. The latter are all former drug addicts, mostly black. The initial seminar was with the executive director, the program nurse, and 11 medical residents. A good deal of anxiety was manifested by the latter group. As the discussion progressed, it became more and more apparent that the thought of working in a program that was really executed by, and day-to-day decisions made by, non-physicians was extremely threatening.[4]

Any abnormalities found on the initial history, physical examination, or laboratory testing were reported to the HDP staff, who were then responsible for medical follow-up. This follow-up would only be conducted by the medical resident if the applicant so decided, and the residents were incensed with the thought that abnormalities discovered by them might be further evaluated and treated by another physician, possibly even in a different hospital. These feelings initially overshadowed the fact that the traditional one-to-one physician-patient relationship had failed in the treatment of this disease which had reached epidemic proportions in our community.[5]

The anxiety, and consequent hostility, were not completely resolved at the end of the first seminar. However, after the residents actually began seeing some of the applicants for the drug program, and after subsequent monthly seminars, they became more comfortable with this new role.

During the first 12 months of operation we have examined somewhat over 200 applicants. Many significant medical problems have been found and reported to the HDP staff. A large percentage of the applicants have returned to the resident who examined them for follow-up of newly discovered medical problems. Additionally, many others have

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returned to the Academic Medicine Service (residents' service) for medical problems which have subsequently developed including four patients with acute bacterial endocarditis.

The monthly joint seminars with the HDP staff have provided progress reports on the program as a whole as well as on particular patients and have also included discussions regarding the whole problem of drug abuse including alcoholism. They have been well received by the residents, as measured by their excellent attendance and participation.

Conclusion

Involvement of medical residents in a hard drug program is an effective educational device and provides a total view of the problem rather than the usual resident inpatient exposure which gives a distorted view consisting largely of complications, such as hepatitis and bacterial endocarditis.

Involvement of physicians in a medical care program not directed by other physicians, produces a good deal of anxiety and hostility. Because a number of diseases, including heroin addiction and alcoholism, do not respond to the traditional one-to-one form of medical treatment, it seems likely that we will see a rapid expansion of these types of programs.

Finally, since we are in a period of experimentation and change in the entire field of health care delivery, it is important for trainees in internal medicine to experience various types of health care delivery systems.[1] This will be helpful to them in evaluating the various new systems that are being evolved and tested, and should help them develop the flexibility to fit more easily into whatever health care delivery systems they eventually enter.

Summary

Involvement of medical residents in a hard drug program can be an effective educational experience, both in the area of drug addiction per se and in learning to function as a member of a health care team which is not physician-dominated.

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MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

MONTHLY SURVEILLANCE REPORT

CASES OF CERTAIN DISEASES
REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH
For the four-week period ending March 1, 1973

	1973 This 4-Week Period	1972 Same 4-Week Period	1973 Total To Above Date	1972 Total Same Date	Total Cases for 1972
Rubella	176	176	267	302	1,460
Congenital Rubella Syndrome	1	0	1	0	1
Measles	275	180	505	398	2,353
Whooping Cough	10	10	22	26	116
Diphtheria	0	0	0	0	1
Mumps	491	407	1,261	826	3,729
Scarlet Fever & Strep Sore Throat	2,189	1,543	4,647	2,860	13,304
Tetanus	0	0	0	0	2
Poliomyelitis (paralytic)	0	0	0	0	0
Hepatitis	308	349	693	860	4,322
Salmonellosis (other than S typhi)	49	41	100	117	781
Typhoid Fever (S typhi)	0	1	1	1	7
Shigellosis	25	40	97	102	574
Aseptic Meningitis	6	3	22	9	266
Encephalitis	8	9	19	17	108
Meningococcic Meningitis	6	3	7	9	55
H Influenza Meningitis	7	5	14	11	81
Tuberculosis	73	132	151	244	1,609
Syphilis	411	441	775	900	4,815
Gonorrhea	2,202	1,642	4,965	3,622	24,728

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, MD, Director
Michigan Department of Public Health

A Unique Feature of Gram-Negative Sepsis

PNEUMOPYOPERICARDIUM

A. Rab Chowdhury, MBBS
Frank Cox, MD, FACP
Detroit

The first reported case of pneumopyopericardium as a complication of gram-negative sepsis occurred in a 41-year-old woman with acute leukemia and diabetes mellitus. This complication resulted from the initial infection at the site of bone-marrow aspiration and subsequently led to her death. While gas-formation in the soft tissues due to *E. coli* infection is rare in non-diabetics, it is not uncommon in patients with diabetes mellitus.

In 1931, Shackelford reported a case of hydropneumopericardium and found only 76 cases of pneumopericardium with pericardial effusion reviewing the past 100 years' literature.[1] Pneumopyopericardium may result from traumatic chest injury or surgical procedure with superimposed bacterial infection. Non-traumatic pneumopyopericardium is a rare entity, but when it occurs, it is almost exclusively due to anerobic organisms.[2]

Acute suppurative pericarditis with pneumopericardium has not previously been reported as a complication of gram-negative sepsis. We observed such a complication in a patient with diabetes mellitus and acute lymphocytic leukemia.

Case Report

Patient D.J., a 41-year-old white female, was admitted to Henry Ford Hospital, Detroit, on Sept. 14, 1971, because of bruises and pancytopenia. She stated that for four weeks prior to admission, she had noticed spontaneous bruises on her arms, leg, and back. Two weeks later, she developed symptoms of of a "cold" consisting of low grade fever, and a blister in the right nasal fossa for which she received medication as prescribed by her private doctor. Following resolution of her above symptoms, she developed general malaise, anorexia, and easy fatigability. Her weight had been fairly stable and she had no other symptoms. The past history was unremarkable except for mild diabetes which was first diagnosed two years before and controlled by diet alone.

On physical examination, she appeared pale but in no acute distress. The temperature was 37.8°C. There was a small denuded area in the right nasal fossa. Multiple ecchymoses were present on the trunk and all four extremities. Non-tender lymphadenopathy was noted in the submandibular regions on both sides. There was no hepatosplenomegaly and the remainder of the examination was essentially negative.

Hemoglobin was 8.1 gm., WBC 1,600 and platelets 23,000 per cu. mm. Differential count revealed 92% lymphocytes, 2% prolymphocytes, 3% "blasts" and 3% neutrophiles. Urinalysis revealed 1+ bacteriuria which on culture grew out *Klebsiella*. Initial blood chemistry including creatinine and uric acid was within normal limits; SGOT was 95, alkaline phosphatase 22.3 Bodansky units and total bilirubin 0.72. Serum protein electrophoresis was within normal limits. Initial blood cultures were negative. Admission chest film was normal as was repeat chest x-ray on 10/18/71 **(Figure 1).** A diagnosis of acute lymphocytic leukemia was confirmed by bone-marrow aspiration from the left iliac crest.

On 9/16/71, she was started on Prednisone 80 mg. orally and Vincristine two mg. I.V. daily. A week later, she had a repeat bone-marrow aspiration from the right iliac crest. Two days later, she developed spiking fever with chills. Blood cultures were obtained and I.V. cephalothin and gentamicin begun. Examination of the bone-marrow aspiration-site (right iliac crest) revealed tenderness, and slight induration which progressed to extensive crepitant cellulitis over the next few days, necessitating incision and drainage. Because of the presence of gas in the soft tissues, infection with gas-forming micro-organisms including claustridia was strongly suspected. Accordingly, intravenous penicillin was begun and cephalothin discontinued. Subsequently, blood cultures as well as cultures taken from the wound grew out *E. coli* (sensitive to cephalothin, gentamicin, ampicillin, etc.). With appropriate antibiotic therapy, the patient became afebrile although her general condition remained otherwise unchanged.

On October 29, 1971, she complained of severe chest pain during coughing. A peculiar, high-

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In this text, pneumopyopericardium and pyopneumopericardium have been used interchangeably.

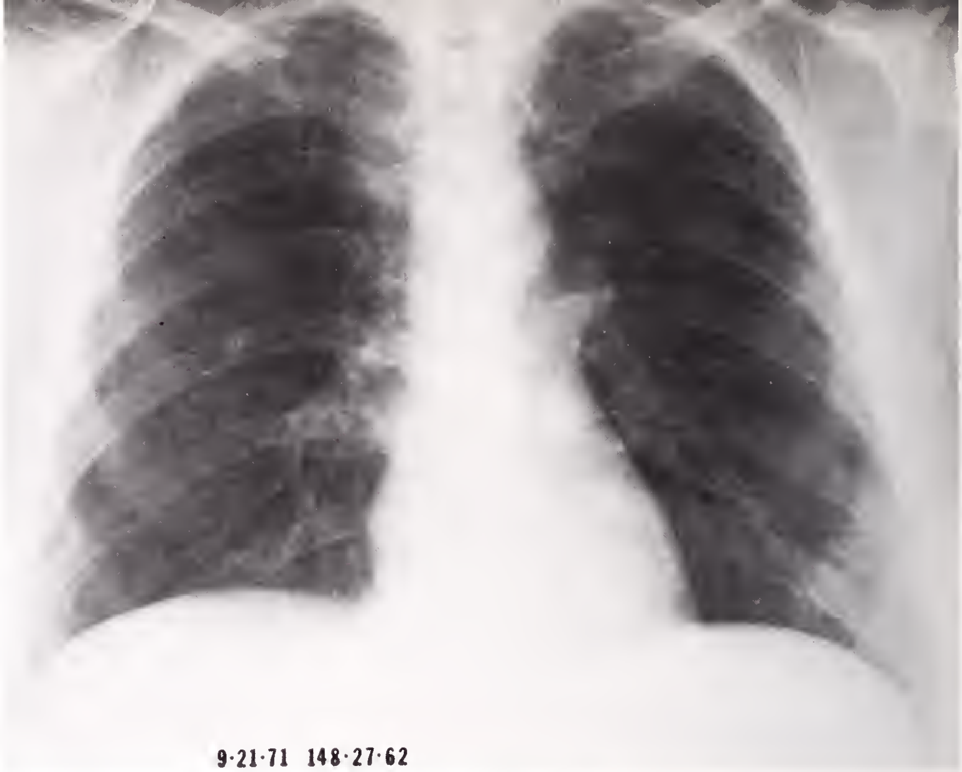

Fig 1 Normal chest film.

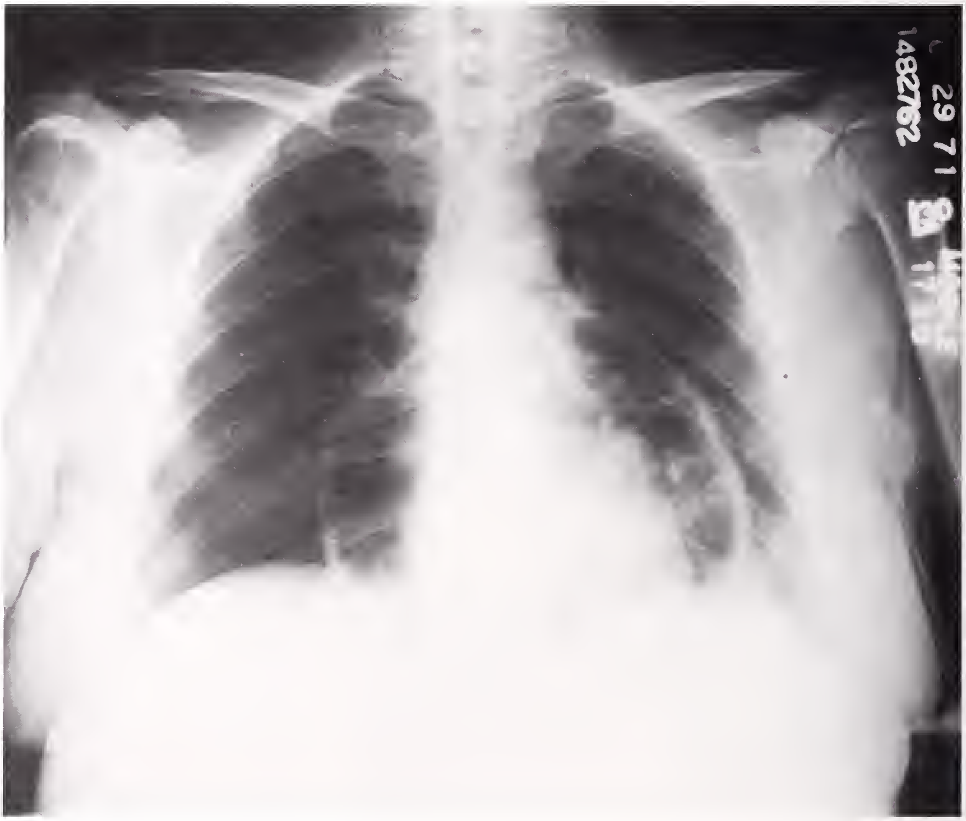

Fig 2 Portable chest film showing Pneumopyopericardium Air distends the pericardial cavity and separates the visceral and parietal pericardium. The dense zone between the cardiac silhouette and air-column represents pericardial fluid.

pitched splashing sound, synchronous with each heart beat was heard on cardiac auscultation. An electrocardiogram showed sinus tachycardia (130/min.) and non-specific ST-T changes in LI, II, V_1 - V_6. A chest x-ray taken at that time revealed pneumopericardium **(Figure 2)**. An upper gastrointestinal series including esophagogram showed no evidence of perforation. Subsequently, she developed symptoms and signs of pericardial tamponade necessitating thoracotomy and pericardial drainage as well as biopsy. Upon opening the pericardium, foul-smelling gas escaped under pressure. The pericardial sac contained about 300 cc of yellowish, foul-smelling pus. Cultures of the pericardial tissue as well as fluid revealed *E. coli, alpha Streptococcus, Candida albicans,* and a few yeast and *Corynbacteria. Anerobic* culture was negative. At the time of the onset of the infection, her blood sugars were in the range of 400 mgm%. And she required insulin to control this throughout the remainder of her hospitalization. She required several blood transfusions to maintain her hemoglobin at a desired level. Despite attempted pericardial drainage and administration of appropriate antibiotics, pus-formation and gas-production in the pericardial cavity continued throughout the course of her illness and her condition deteriorated steadily. Finally, she died of overwhelming sepsis on 11/24/71.

Discussion

Although the study of pericardial fluid and biopsy revealed growth of other organisms, the predominant organism was *E. coli* which had also been isolated from the bone-marrow aspiration site and blood. Pyopneumopericardium secondary to esophagopericardial fistula or perforation of benign gastric ulcer has been previously reported.[2-4] To exclude these possibilities an upper gastrointestinal series including an esophagogram was done which showed no evidence of fistulous communication or perforation. Meyer in his excellent review on pneumopyopericardium quoted six cases of non-traumatic pneumopericardium - all were due to *Cl. welchii* infection.[2] Recently, Kapoor and Shah reported two cases of pyopneumopericardium following amebic liver abscess of the left lobe.[5]

Acute leukemia, diabetes mellitus, antileukemic therapy including steroids are all known to predispose to infection.[6,7] In a retrospective study of 104 patients with acute leukemia, Burgess et al reported *E. coli* and *P. aeruginosa* were the bacteria most frequently identified, accounting for 31 (43.6%) of the total. These authors stated that granulocytopenia was probably the most significant predisposing factor in the development of these infections; this resulted from either the disease itself or its treatment or both. This view was supported by earlier observation by Viola who also noted infection was the major single cause of death in acute leukemia.[8]

Reviewing case records of eight hundred and seven diabetics undergoing surgery, Ariyan and Halasz[7] found that the incidence of gram negative infection was eighteen times that in the general population undergoing similar procedures and the most common organism identified was *E. coli.* Baum et al described abnormal chemotaxis in patients with diabetes mellitus.[9] Apart from crepitant cellulitis,[10] the coliform bacteria may also cause gas-formation in hollow organs.[11-14]The pathogenesis of non-clostridial suppurative inflammation with gas-formation is not fully understood. Although it is possible that the high tissue glucose levels provide the substrate for organisms which are able to produce carbon dioxide by fermentation of sugar, this explanation alone does not account for the rarity of emphysematous inflammary reactions in hollow organs, particularly in non-diabetics. In any event, the presumed substrate for bacterial fermentation in both diabetics and non-diabetics is glucose.[13]

In our patient, perhaps associated leukemia and diabetes mellitus, causing impaired response on the part of the host, have allowed uncontrollable proliferation of the gas-producing organisms which have the capacity of producing carbon dioxide in vitro to utilize necrotic tissue as substrate to generate gas in vivo. A chest roentgenogram, pericardiocentesis, culture of blood, pericardial tissue and pus established the exact anatomical and etiologic diagnosis, Pneumopyopericardium with *E. coli* bacteremia. To our knowledge, acute suppurative pericarditis with gas formation as a complication of gram negative sepsis has not been previously reported.

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Doctor: Are you screening your female patients for gonorrhea?

(The following information is available on a handy pocket-size card published by the Michigan Department of Public Health.)

1. Gonorrhea can be detected before it becomes symptomatic.

2. Pelvic inflammatory disease, arthritis, tenosynovitis, endocarditis, conjunctivitis, perihepatitis, salpingitis, meningitis, and ophthalmia neonatorum may all be complications of gonorrhea.

3. Complications of gonorrhea may be prevented by early detection and treatment.

4. Removal of asymptomatic females may greatly reduce the high incidence of gonorrhea in the general population.

Who should be screened?

Female patients who are:

1. Receiving medical care which requires a pelvic examination.
2. Under 35 years of age.
3. Pregnant
4. Named or admitted contacts to male gonorrhea cases.

Advice on screening procedures.

Thayer-Martin Plates are used when there is immediate access to a laboratory; on the other hand, Transgrow Bottles are used for sending specimens to a central laboratory.

Culture sites—female:

1. Endocervical—the best site to culture.
2. Rectal—most likely site to be positive when cervix is negative.

Thayer-Martin Plates:

Roll swab on medium in a large "Z" pattern. Cross-streak immediately with a sterile wire loop. Place culture in a candle jar as soon as possible. Begin incubation of plates the same day.

Transgrow bottles:

Caution: Keep neck of bottle in elevated position to minimize CO^2 loss.

Soak up all excess moisture in bottle with specimen swab and roll swab from side to side across medium, starting at the bottom.

When possible, incubate in an upright position at 35-37°C for 16-18 hours before mailing and note this on accompanying request form.

Package capped bottle and transport to central lab by postal service or other convenient means.

Thayer Martin and Transgrow supplies may be obtained free of charge from your local health department.

PERINATAL TIPS/Continued

Death occurred on the 10th day of life. An autopsy was done that revealed thrombosis of the left renal artery with massive infarction of the left kidney, a patent ductus arteriosus associated with diffuse hepatic necrosis, resolving subacute-pneumonitis due to relatively widespread aspiration of amniotic sac content and subarachnoid hemmorrhage of the spinal cord.

Perinatal Committee Comments:

1. Although this infant eventually expired, credit must be given to the pediatrician here for he realized reasonably early he had a very ill infant on his hands, that needed all the expert care available. He sought that care by transferring the infant to a well-run NICU.

2. A large infant such as this one (10 pounds 5½ ounces) should clue one as to the possibility that the mother is a potential diabetic. She should have had appropriate studies done (FBS or 2 hours post prandial blood sugar or glucose tolerance test) while in the hospital and periodically thereafter and if overweight, efforts to get her to reduce should be made.

3. Among other diagnoses that could have been entertained before death include digitalis intoxication, congenital heart (total anomalous venous return? one chambered heart?), intracerebral accident and myocarditis (secondary to coxachie infection).

Commission phone listing rules

The MSMS Judicial Commission reminds Michigan physicians that telephone directory listings not in the physician's immediate area of residence or practice are inappropriate.

The Judicial Commission makes its recommendation following the AMA Guidelines for Telephone Directory Listings for Physicians and Surgeons, published in 1966:

> "The name of a physician should not be listed in a telephone directory of a locality where he does not have an office, residence, or hospital affiliation. An exception to this general guide may be necessary in larger metropolitan areas because of the growth pattern of the community or because telephone directories are subdivided according to geographic areas. Under these conditions a physician's name, to be properly identified for community services, may appear in a directory of a locality in which he does not have an office, residence or hospital affiliation in accordance with specific guidelines established by the local medical society or societies in these areas."

Familial erythema nodosum

By Otelio S. Randall, MD
William S. Abernathy, MD
Blake Berven, MD
Ann Arbor

Erythema nodosum is usually considered an acute, sporadic eruption associated with a precipitating event. However, familial and chronic benign forms have been reported. In the previously described familial forms there has usually been a common precipitating event shared by affected individuals, such as tuberculosis,[1-9] tonsillitis,[6] rheumatic fever,[10] or the associated event has not been stated.[5,11] Symes reported one family with erythema nodosum in which there was no common precipitating event, although one daughter had tuberculosis.[1] We report chronic erythema nodosum in a mother and daughter and acute erythema nodosum in another daughter; no common precipitating event is evident.

Case Reports

Case No. 1

V. G. (UMMC No. 881-615), a 50 year old female of Italian descent, the mother of C. G. and J. R. (cases No. 2 and 3), reports that at age nine she had painful, red, raised lesions on her legs with a febrile illness. At age nineteen she was kept in bed for several months because of joint and chest pains ascribed to rheumatic fever; she had painful nodose lesions at that time.

In 1951 and 1952 she had recurring painful nodose lesions on her legs, forearms, and back. A biopsy showed typical erythema nodosum. A chest film revealed bilateral hilar adenopathy and a right upper lobe infiltrate, none of which was present four years previously. An old tuberculin skin test was positive. The chest film returned to normal one month later and has remained normal in 1957 and 1971 without anti-tuberculous treatment.

The patient has had recurring painful, red, raised lesions on her legs, upper extremities, face, and back since 1951 without any discernible precipitating event. In July 1971 a physical examination, hemogram, and urinalysis were normal. An intradermal intermediate PPD was positive. When seen in February 1972, she had typical erythema nodosum.

Case No. 2

C. G. (UMMC No. 1228-953), a 17 year old female, developed pharyngitis in July and August 1970 and was given erythromycin estolate each time. In February 1971 she developed tonsillitis and cervical adenopathy and was again given erythromcycin estolate. Within one week she manifested weakness, icterus, dark urine, and painful, red, raised lesions on her legs, forearms, and back. The spot test for infectious mononucleosis was positive and a tuberculin tine test was negative. Erythromycin estolate was discontinued, and her icterus disappeared within a week.

The skin lesions and sore throat persisted over the next five months, during which time she was intermittently given prednisone. In July 1971 a physical examination revealed moderately enlarged tonsils without exudates, a spleen palpable one centimeter below the costal margin, and erythema nodosum on her legs. (Her private physician reports a palpable spleen for the prior two years in this slender patient.) A hemogram, urinalysis, serum glutamic oxalacetic transaminase (SGOT), bilirubin, alkaline phosphatase, and serum proteins were normal. The Ortho Mono Spot test, anti-streptolysin-O (ASLO) titer, throat culture, and Venereal Disease Research Laboratory (VDRL) test were negative. Intradermal tests for intermediate PPD, coccidioidomycosis, and histoplasmosis were non-reactive; *Candida albicans* was reactive. Chest film and barium enema were normal. A biopsy revealed erythema nodosum.

She has continued to have recurring skin lesions; when seen in February 1972, she had typical erythema nodosum.

Case No. 3

J. R. (UMMC No. 1229-579), a 26 year old female, developed pharyngitis in March 1971. One month later, after the extraction of teeth under halothane anesthesia, she developed a cough productive of green sputum of two weeks duration, at the end of which time she noted pain and swelling in her ankles and left foot. A few days later she had painful, red, raised lesions two to four centimeters in diameter on her legs. These resolved into painless ecchymoses over the next two weeks.

From May to July 1971 she had a non-productive cough and mild dyspnea but had no chills, fever, or weight loss. Physical examination in July 1971 was normal except for ecchymoses where the nodose lesions had been. Chest films in June and July 1971 revealed right paratracheal and bilateral hilar adenopathy with clear lung fields. An intradermal intermediate PPD was non-reactive and a mumps skin test was reactive. Complement fixation tests for coccidioidomycosis and histoplasmosis were

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negative. The hemogram, urinalysis, Venereal Disease Research Laboratory (VDRL) test, serum calcium, and serum proteins were normal.

Unfortunately this patient did not return for further evaluation, but the mother reports that she has had no more dyspnea or erythema nodosum as of February 1972 and that she appears to be in good health

Cases No 4 and 5

V. G. reports that her son had recurring leg lesions, identical to hers, until he was 12 years old. She also states that her great-uncle had nodose skin lesions and that a family physician commented on the similarity of their lesions. No further details are available on either case.

Comment

All of the first three cases demonstrated typical erythema nodosum, and a biopsy confirmed the diagnosis in cases No. 1 and 2. The mother's report of erythema nodosum in cases No. 4 and 5 is of great interest, but the diagnosis is not secure in those patients.

Cases No. 1 and 2 have the chronic, benign form, recently described in detail,[12] although many authors note the recurrent form of erythema nodosum.[1,8,13-16]

The cause of the pulmonary infiltrate and hilar adenopathy in case No. 1 is unknown, but tuberculosis seems unlikely with the rapid resolution without anti-tuberculous therapy.

The precipitating event in case No. 2 may have been tonsillitis, possibly due to infectious mononucleosis.[17] The jaundice may have been caused by erythromycin estolate toxicity. Sequential negative skin tests and a normal chest film make tuberculosis unlikely, although the recognition of tuberculosis may be delayed in the presence of erythema nodosum.[9,16,18]

The precipitating event in case No. 3 is unclear; it may have been tracheobronchitis following anesthesia. Her hilar adenopathy could not be studied further, and so its nature remains conjectural, although it probably was the benign adenopathy associated with erythema nodosum.[9,18,19]

Discussion

The available evidence favors the view that some persons are more prone to manifest erythema nodosum than others and that there is a familial aggregation. Holmdahl[8] found that 28% of his patients with erythema nodosum and primary tuberculosis had a family member with erythema nodosum. Roosvall[5] observed a similar frequency of involvement in the families of patients with erythema nodosum whether or not they had tuberculosis; he did not give the details of his cases. Many have speculated that erythema nodosum is a hypersensitivity phenomenon,[18] and there is evidence that other immunologically mediated diseases may have a familial aggregation.[20]

The family reported here is of interest for three reasons: (1) family members in two, and possibly three, generations had erythema nodosum; (2) unlike almost all previous case reports, no common precipitating event is evident; (3) two individuals have the less common chronic benign form of erythema nodosum. This family lends support to the idea that erythema nodosum may be in part due to familial factors.

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Carcinoma of the colon associated with ureterosigmoidostomy:

Report of an Unusual Case

James William Myers, MD
Ann Arbor

Carcinoma of the colon is not an unusual disease. However, in the age group under 30 it is somewhat less common and is not frequently seen in the general surgical practice. Even less frequently it is seen in association with other congenital or familial diseases. Literature available on adenocarcinoma of the sigmoid colon associated with ureterosigmoidostomy is even less frequent.[1-7] The case presentation here has an interesting history and unusual findings at surgery.

Case Presentation

K.M. is a 27 year old white male who was born with total hypospadias and exstrophy of the bladder.

Early intravenous pyelography revealed normal upper renal systems bilaterally. Within the first year of life he underwent correction of the exstrophy of the bladder as well as bilateral ureterosigmoid implants. Over the next several years repeat intravenous pyelograms eventually showed total loss of function of the right kidney but with no evidence of continuing urinary tract infections.

When the patient was 16 years of age, he began having recurrent problems with kidney infection and the left ureterosigmoidostomy was taken down and a cutaneous ureterostomy was performed on that side. No surgical intervention was undertaken on the right side. Since that time in the last nine years the patient has been asymptomatic. He's been in excellent general health.

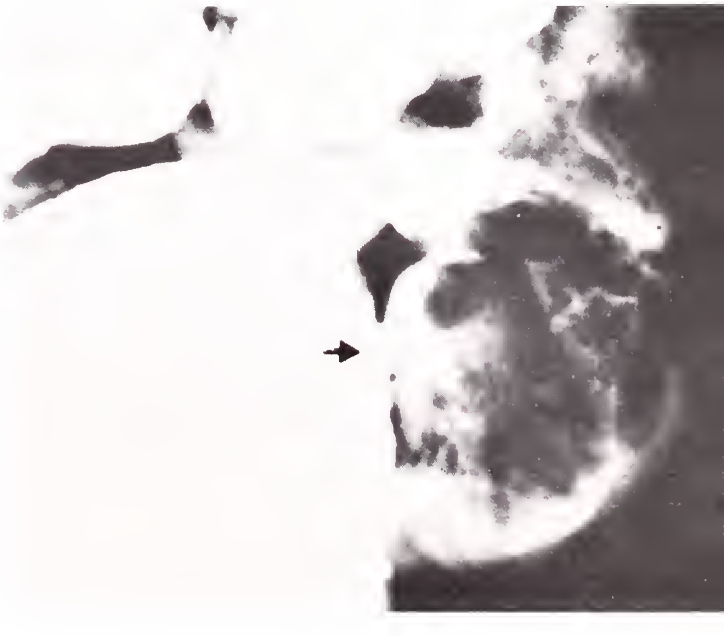
Mr. M. presented to our emergency room in May, 1970 with massive bright red blood per rectum. At the time of presentation to our emergency room and after initial evaluation he was taken to the sigmoidoscopy room where this was performed and at approximately 16 centimeters a five to seven centimeter bleeding papillomatous lesion was seen. The majority of this was removed at the time of sigmoidoscopy with adequate control of the hemmorrhage. He was admitted to the hospital and a repeat hemoglobin revealed a 2 gram hemoglobin drop from the rectal bleed. Frozen section of this initial material was benign; however, permanent sections revealed adenocarcinoma with possible invasion.

After stabilization for three or four days, further studies were carries out. A barium enema was done which showed a large filling defect at upper sigmoid colon (**Fig. 1**). Because of the history of having already removed a large polyp, the radiologist was uncertain of his findings and a repeat barium enema was performed and revealed a persistent large defect of the sigmoid colon; however, nothing was identified at the 16 centimeter level.

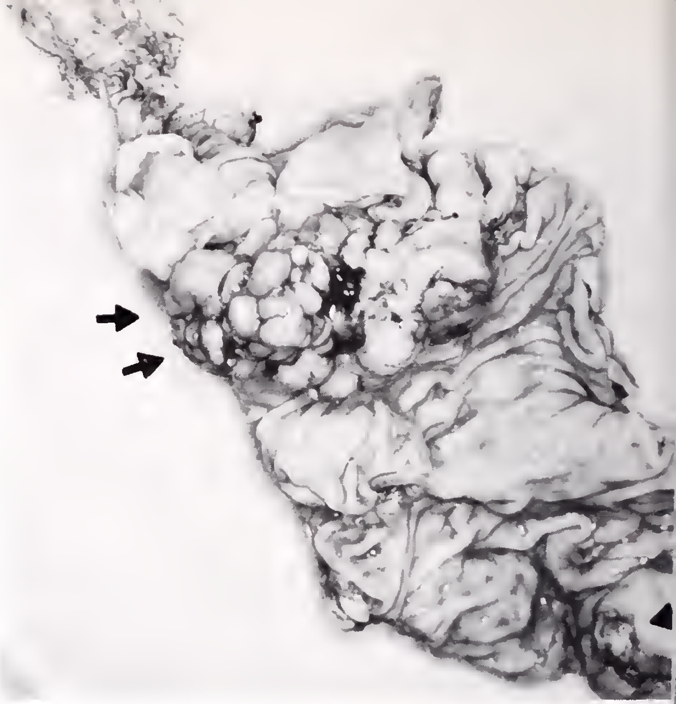
After a mechanical and antibiotic bowel prep this young man was taken to surgery and at the time of surgery, a second large lesion was found as outlined on x-ray (**Fig 2**).

The site of the previous lesion was found as expected at about 16 centimeters as a small nubbin in the sigmoid mucosa (**Fig. 2**). The most interesting

Legend Fig 1
Arrow showing defect on barium enema



The author is with the Department of General Surgery, St. Joseph Mercy Hospital, Ann Arbor.



Legend Fig 2
Double arrows pointing to upper lesion shown on barium enema. Single arrow site of lesion removed per sigmoidoscope.

feature of this is that it was at the site of the right ureterosigmoidostomy and the right ureter was still in place into the sigmoid colon. The ureter was fibrotic and enlarged to a diameter of one centimeter and a specimen was taken for pathologic section at that time. No neoplasm was found in the ureter.

The right ureter was ligated and transected approximately 5 centimeters from the sigmoid colon. Because of the fact that there were two separate lesions, it was decided to do a descending colon resection and sigmoid resection and this was carried out, having adequate free margins both above the proximal lesion and distal to the lower lesion. The colon anastomosis was carried out at 10 centimeters without a great deal of difficulty primarily because of the spread of the pubic rami from the exstrophy of the bladder.

Postoperatively this gentleman had no complications and the final pathology report revealed that both lesions were indeed adenocarcinoma and that both lesions arose from the site of implantation of the previous ureters. There was no evidence of transitional cell epithelium in either specimen. Neither lesion was invasive of the bowel wall, however it was more extensive than a true in situ lesion. No evidence of metastases were noted at the time of operation. The patient was discharged home on the 7th postoperative day and has had a 21 month follow-up without evidence of any significant problems.

Discussion

As previously mentioned, the finding of a single colon carcinoma at the age of 27 is not very common and the possibility of finding two concurrent lesions is a person at this age is even less remote, especially considering the fact that there is no previous history of ulcerative colitis or any familial polyposis.

In addition, the association of both of these separate primary lesions with the previous bilateral ureterosigmoidostomy is of utmost interest. Whether there is an ideopathic relationship or if this is mere coincidence one cannot be certain. In reviewing the literature one finds only a limited number of reported cases (**Table 1**).

One is impressed with the increased evidence of carcinoma of the colon with ureterosigmoidostomy and this problem warrants sigmoidoscopic and barium studies as part of the continuing care of these patients.

Summary:

Massive rectal bleeding from two sigmoid carcinomas presenting in a patient with bilateral ureterosigmoid implants as an infant. Available literature is reviewed and tabulated.

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Table I

Colonic Neoplasms Following Ureterosigmoidostomy: Review of World Literature

Author	Age yr	Sex	Colon Lesion	Site in colon	Procedure	Reason for procedure	Latent Period yr
Hammer	60	M	"Colloid carcinoma"	Vesical remnant	UVS	Exstrophy	10+
Dixon & Weismann	33	M	Adenomatous polyp & adenocarcinoma	Near ureteral orifice	US	Exstrophy	30+
Riches & Page	62	F	Transitional cell carcinoma of colon	Distal to ureteral orifice	US	Transitional cell carcinoma of bladder	1+
Gillman	52	M	3 adenomatous polyps	At ureteral orifice	US	Papilloma of bladder transitional cell	7
Massachusetts General Hospital (Case No. 44052)	63	M	Adenocarcinoma	At ureteral orifice	US	Transitional cell carcinoma of bladder	8
Wilson	47	F	Anaplastic carcinoma of colon	Near ureteral implant	US	Congenital urinary incontinence	30
Amar	30	M	Transitional cell carcinoma of colon	At ureteral orifice	US	Transitional cell carcinoma of bladder	4+
Aldis	33	F	Anaplastic carcinoma of colon	At ureteral orifice	US	Exstrophy	15
Ellis	55	M	Adenomatous polyp	At ureteral orifice	US	Abacterial cystitis	15
Scheinman	51	M	Mucinous adenocarcinoma of colon	At ureteral orifice	US	Transitional cell carcinoma of bladder	9
Sugg	21	F	Mucinous adenocarcinoma of colon	At ureteral orifice	US	Interstitial cystitis	17
Kozak et al	17	M	Mucin producing adenocarcinoma of colon	At ureteral orifice	US	Exstrophy	15
Urdaneta et al	40	F	Mucinous adenocarcinoma of colon	At ureteral orifice	US	Interstitial cystitis	17
Urdaneta et al	64	M	Adenocarcinoma of colon	At ureteral orifice	US	Squamous carcinoma of bladder	9
Urdaneta et al	34	F	Undifferentiated carcinoma of colon	Not stated	US	Exstrophy	30
Kille	26	M	Adenocarcinoma of colon	At ureteral orifice	US	Incontinence due to epispadias	16
Kille	19	M	Mucous polyp of colon	Near ureteral orifice	US	Incontinence due to epispadias	15
Richter	24	M	Adenocarcinoma of colon	At ureteral orifice	US	Exstrophy	22
Harrison			Adenocarcinoma of rectum	Between sites of ureteral implant	US	Transitional cell carcinoma of bladder	2
Ferguson	30	M	Polypoid adenocarcinoma of colon	At ureteral orifice	US	Exstrophy	26
Haney & McGarity	44	F	Adenomatous polyp of colon	At ureteral orifice	US	Exstrophy	38
Current report	27	M	2 Adenocarcinomas of colon	At both ureteral orifices	US	Exstrophy	26

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Michigan authors

ARTICLES

Richard C. Bates, MD, Lansing, "Behavioral Medicine should be the next big specialty," page 113, *Medical Economics,* Feb. 5, 1973.

Robert C. Carpenter, MD, Ann Arbor, "The Academic Medical Center and the Regional Medical Program," page 178, *Journal of Medical Education,* February, 1973.

A. A. Farbman, MD, Detroit, "Neck Sprain," page 1010, *Journal of the American Medical Association,* Feb. 26, 1973.

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W. Paul Reagan, MD, Detroit, "Treatment of tuberculosis in the general hospital," page 3, *Clinical Notes on Respiratory Diseases,* Spring, 1973.

MOVIES

Rodman E. Taber, MD, Detroit, "Closure of Sternotomy Wounds," presented at annual meeting, Society of Thoracic Surgeons, Houston, Texas, Jan. 22, 1973.

BOOKS

Chris J. D. Zarafonetis, MD, Ann Arbor, editor, "Drug Abuse, Proceedings of the International Conference," Philadelphia, Lea and Febiger, 1972.

Michigan mediscene

April 14 — Health Professions Day, for members of high school health careers clubs, at Michigan State University, contact: John A. Doherty, executive vice president, Michigan Health Council, 712 Abbott, East Lansing, 48823.

April 25 — Allied Health Arthritis Seminar, Michigan Chapter, Arthritis and Rheumatism Foundation, Sparrow Hospital, Lansing, contact: Michigan Chapter, ARF, 27308 Southfield, Lathrup Village.

April 25 — Physicians for Michigan Communities Day, sponsored by Michigan Health Council, at Scott Hall, Wayne State University School of Medicine, contact: John A. Doherty, executive vice president, MHA, 712 Abbott, East Lansing, 48823.

April 26-29 — Annual State Convention, Michigan branch, AAMA, Dearborn Inn, Dearborn, contact: Margaret Broadwell, 406 Professional Plaza, 3800 Woodward Ave., Detroit, 48201.

May 2 — Thirteenth annual Clinical Conference, Bronson Methodist Hospital, Kalamazoo, subject: "Acute medicine and emergency care," contact: Russell E. Watson, Jr., director, Public Relations and Volunteer Services, Bronson Hospital, 252 E. Lovell, Kalamazoo, 49006.

May 4-5 — Sixth annual cancer symposium, "Management of Advanced Breast Carcinoma," sponsored by Wayne State University School of Medicine, American Cancer Society, Michigan Division, and Michigan Cancer Foundation, at Wayne County Medical Society headquarters, $25 fee, contact: Mrs. Dorothy Bewley, symposium registrar, 4160 John R Street, Detroit, 48201.

May 5 — 18th annual all-day scientific session of the Michigan Society of Anesthesiologists, Sheraton-Cadillac Hotel, Detroit, contact: Thomas J. DeKornfeld, MD, MSA secretary-treasurer, Room S-6352, University Hospital, Ann Arbor, 48104.

May 9 — 105th Annual Clinic Day and Reunion Banquet, WSU School of Medicine Alumni Association, Detroit Hilton Hotel, contact: Donald Burkholder, University Relations, School of Medicine, Wayne State University, Detroit, 48201.

May 9 — Seminar, "Diseases of the Reticuloendothelial System," Michigan Society of Pathologists, Scott Hall, Wayne State University School of Medicine, contact: Jacob E. Briski, MD, Saint John Hospital, 22101 Moross Road, Detroit, 48236.

May 9-12 — Seminar, "Life-Saving Measures for the Critically Injured," sponsored by American College of Surgeons' Committee on Trauma, Wayne State University, contact: Alexander J. Walt, MD, chairman, Department of Surgery, WSU School of Medicine, 540 E. Canfield, Detroit, MI 48207.

May 10-11 — Sixteenth Annual Clinic Days, Children's Hospital of Michigan, Detroit Medical Center, contact: Edward W. Green, MD, Children's Hospital, 3901 Beaubien Blvd., Detroit, 48201.

May 13-15 — Second Annual Spring Meeting, MSMS House of Delegates, Boyne Mountain Lodge, Boyne Falls, contact: Richard Campau, MSMS headquarters.

May 15-16 — Spring Conference, Woman's Auxiliary to MSMS, Hidden Valley Lodge, Gaylord, contact: Mrs. Fleming Barbour, 2015 Lincoln Drive, Flint, 48503.

May 16-18 — Annual meeting, Michigan Public Health Association, Olds Plaza Hotel, Lansing, contact: Mrs. Anna Langela, executive secretary, MPHA, 403 Seymour, Lansing, 48914.

May 18 — Centennial Luncheon honoring the 100th year of the Michigan Department of Public Health, Olds Plaza Hotel, Lansing, contact: John Cook, Department of Information and Education, MDPH, 3500 N. Logan, Lansing, 48914.

May 23 — Council of Specialty Societies, 2 p.m., MSMS headquarters, contact: Glenn E. Moore, MD, president, 323 W. Second, Flint, 48503.

May 24 — Michigan Conference on Rural Health, sponsored by MSMS, Michigan Health Council, MSU, at Kellogg Center, East Lansing, contact: John A. Doherty, Executive Vice President, MHC, 712 Abbott, East Lansing, 48823.

June 1-2 — Annual Keyport Trauma Day, Hidden Valley Lodge, Gaylord, contact: B.E. Henig, MD, 308 Michigan Ave., Grayling, 49738.

June 15-16 — 80th annual meeting, Upper Peninsula Medical Society, Pine Mountain Lodge, Iron Mountain, contact: John Schroeder, MD, 212 E. B Street, Iron Mountain, 49801.

June 20 — The Council, MSMS headquarters, contact: Warren Tryloff, director.

June 22-24 — Annual meeting, Michigan Orthopaedic Society, Hidden Valley Lodge, Gaylord, contact: George D. Stilwill, MD, Lansing Medical-Dental Building, 2909 E. Grand River Ave., Lansing, 48912.

June 25-29 — Annual Northern Michigan Summer Course, "Diagnosis and treatment of some common medical problems," sponsored by U-M Department of Postgraduate Medicine, at Shanty Creek Lodge, Bellaire, contact: Ralph Lewis, Towsley Center, The University of Michigan Medical Center, Ann Arbor, 48104.

Oct. 7-11 — 108th MSMS Annual Session, Sheraton-Cadillac Hotel, contact: Helen Schulte, for Scientific Sessions information, and Richard Campau, for House of Delegates information, both at MSMS headquarters.

From left, Richard Mellis, MD, Fred L. Clement, MD, and William S. Skellenger, MD, in the cockpit of their air ambulance.

Meet some interesting Michigan physicians . . .

These Kalamazoo doctors own air ambulance company

Kalamazoo Physicians Leonard Brunette, MD, Fred L. Clement, MD, Richard Mellis, MD, and William S. Skellenger, MD, wanted to buy an airplane last fall, anyway.

At the same time, a local ambulance company was looking for a plane (and someone who would fly it) that would accommodate injured and ill persons that needed to be transported but did not need acute care.

So the two groups got together, the doctors bought a plane suitable for the ambulance company's needs, and the doctors now are partners in a company they call Medic-Air. ("If you say it fast, it sounds like Medicare," quips Doctor Mellis.) The owner of the ambulance company is on the board of directors.

Doctors Brunette, Clement, Mellis and Skellenger bought a Piper Seneca, a twin-engine with an extra-large door that allows stretchers and patients to be carried on and off with relative ease. It is fully equipped with the latest instruments.

Medic-Air is licensed to go anywhere in the 48 contiguous states to transport anyone who needs or wants to be moved and is past the acute care stage of his injury or illness and is unable to travel on commercial airlines.

When a trip is made the physicians hire a professional pilot and also will provide any medical personnel and equipment needed for the patient's best care.

"Our instruments—defibrillators, resuscitators, incubators, monitors, oxygen tanks — and our trained personnel—nurses, physicians, ambulance attendants, emergency room technicians —are something we can provide that other charter air companies would have difficulty offering," says Doctor Mellis.

The doctors of Medic-Air also are able to consult with the patients' physicians with knowledge and experience, so that the patient is assured good care on his flight.

Medic-Air received its approval by the FAA as an air taxi or charter service in October, and since then has been called on nearly once a week to transport ailing persons in or out of Michigan. In addition, it has been chartered by a Kalamazoo hospital group attending a meeting in Cleveland.

"Our air ambulance service is not for every traffic accident," says Doctor Mellis. Examples of the type of service its owners expect Medic-Air to make on a regular basis are its recent transport of a traffic victim from New Mexico to his home town in Michigan and the flight to Michigan of a coronary victim who suffered his attack in Florida. On the first trip, a nurse was in attendance; on the latter, a physician went along.

"We're trying to make a go of this," says Doctor Mellis. "We don't expect to make a lot of money with it, but so far the company is paying for itself."

The doctors may use the plane for vacation trips with their families when it is not being used by Medic-Air. All have their multi-engine licenses. In addition, Doctors Clement and Brunette have their instrument ratings, and Doctor Brunette has his commercial pilot's license.

Doctor Carpenter has his own private zoo

C. J. Carpenter, MD, of Romulus pushed open the door of a low, white building next to his home in Romulus.

He got a warm greeting. Several geese honked noisily, pheasants squawked, two Russian wild boar grunted and snuffled excitedly and "Porky" the peccary rubbed vigorously against the doctor's leg. As Doctor Carpenter continued, "Buzz" the buzzard flapped excitedly about his cage, "Hootenanny" the owl swept close, and a turtle obligingly stuck its neck out to be scratched.

"Doc" Carpenter knows what the turtle likes. "See, if he were frightened, he'd be all retracted," he said.

Coyotes paced warily in their outdoor pens, monkeys ate fruit while looking blandly at the doctor from their cages and "Bobbie" the bobcat engaged in a boxing demonstration, made safer by the fact that Bobbie was declawed.

It was an unlikely series of sights incongrously set in the metropolitan Detroit area and made more unlikely with the knowledge that Doctor Carpenter has kept herds of buffalo and two pet black bears on the premises, too.

His farmhouse and 35 acres surrounded by urban sprawl are all that remain of the 120 acre farm bought nearly 70 years ago by Doctor Carpenter's father.

The love and care Doctor Carpenter shows his menagerie are just one phase of the amazing Clarence Carpenter, MD. At 79 he still cares for an average of 40 patients per day, serves as an assistant Wayne County medical examiner and provides emergency care for 120 small business firms and six airlines with bases at nearby Metropolitan Airport.

C. J. Carpenter, MD, Romulus, feeds tidbits to his bull buffalo.

"I raise the animals to get away from work," says the doctor. Mrs. Carpenter, a registered nurse, and his assistant, Miss Faye Moody, RN, explain that his office hours are from 8 a.m. to 8 p.m. Monday-Friday and include Saturday and Sunday mornings. In addition, he's on emergency call 24 hours a day, and, according to friends, is never too busy, no matter what the hour, to give aid.

From 1929 to 1965, Doctor Carpenter owned and ran the 85-bed Wayne General Hospital, which later became Carpenter Hospital. Urban renewal efforts forced him to close his hospital, and when the city of Wayne would not sell him the land for another, Doctor Carpenter built his current clinic two years ago in Romulus.

Doctor Carpenter is a long-time member of the Detroit Zoological Society. As a boy, he trapped and tamed skunks, woodchucks, squirrels and raccoons. He's continued to own and enjoy wild animals since.

"All wild animals tame easily if you don't force yourself on them," he claims.

Twenty years ago, the Detroit Zoo asked Doctor Carpenter to raise buffalo for them, as zoo officials were afraid the animals would become extinct. Since then, Doctor Carpenter has raised buffalo, giving some to the zoo, and providing the foundations for six or seven private herds throughout the state.

Doctor Carpenter also has given the zoo coyotes, a coatimundi and turtles.

The University of Cincinnati Medical School graduate has hired a man to help in caring for the animals. The Carpenters buy quantities of over-ripe fruit from Detroit vendors for some of the animals and provide much raw meat for others.

And they share a mutual love for each of their four-footed tenants.

"Buzz thinks he's a peacock," says Mrs. Carpenter, even demonstrating a fondness for the buzzard.

"Would you believe that I carried those boars one in each arm when we got them as babies?" she continues, looking in on the specimens which weigh 400 pounds apiece now.

The Carpenters claim a person would never have a domestic cat again if he could have a bobcat as a pet, that the peccary is housebroken and will sit on the couch and eat ice cream with guests.

They speak most fondly of the black bear, "Teddy," which they had for 19 years until his death two years ago. Teddy, who lived to an advanced age for his species, was caught by Doctor Carpenter's

(Continued on page 293)

Doctor Clarke is a distinguished book collector

Norman E. Clarke, MD., tells of the day, years ago, when he walked into an old book shop in Detroit, and his hand reached, as though guided, for the still only known copy of an old book published in 1811 at Detroit by The Richard Press—the first real press in Michigan Territory.

That exciting discovery stimulated him to amass over the years an extensive collection of printed books and pamphlets, issued by Father Richard's press; a superior collection of early Mormon publications, largely of the Beaver Island Strangite sect; a superior collection of old and rare children's books and a large and comprehensive collection of early Northwest Territory manuscripts and books.

In his lifetime, Doctor Clarke has distinguished himself as a cardiologist and medical researcher. He established the cardiology units at both Henry Ford and Grace Hospitals in Detroit. In 1923 he brought the first operating electrocardiograph machine to Henry Ford Hospital and Detroit, and under him the Grace Hospital had the largest free heart clinic in the United States.

It is a seventh grade teacher, a woman of mixed racial heritage, to whom Doctor Clarke attributes his interest in children's literature. That teacher would reward her students by reading good children's books to them. Among the volumes she read were "Tom Sawyer" and "Huckleberry Finn."

Then, when a friend's father loaned the young Norman Clarke an earlier edition of Mark Twain's "Innocents Abroad," his first impulse to collect old books was born.

Subsequently, his collection of the writings by Mark Twain became one of the most complete in the U.S.

The Mark Twain collection was the first major gift Doctor Clarke made to Central Michigan University, in his boyhood town of Mt. Pleasant, and later it was included in his major gift, the Clarke Historical Library, established at CMU in 1956.

"I believe the sage advice of Oliver Wendell Holmes, that "the only things we really keep in life are the things we give away," says Doctor Clarke. "I find great pleasure in giving cultural and research items to places where they will be treasured and used."

The Clarke Historical Library now houses all of Doctor Clarke's rare books and encompasses also the Mark Twain Collection and the Lucile Clarke Memorial Children's Library named in memory of Mrs. Clarke, who passed away in 1968.

Doctor Clarke adds that other reasons he gave his books to CMU were "to stimulate minds to do real historical research and enrich our knowledge, also to enhance the faculty prestige."

"So much historical and other faculty writing is poorly done," Doctor Clarke laments, "because the writers know advancement is based on the number of their publications. Hence they seek to publish much without enough attention to quality."

When Doctor Clarke began book collecting there were few collectors and a relative abundance of good and rare books and early manuscripts.

"But that is not true today," he says. " You are lucky to find a real rarity today. And unfortunately, rare books and manuscripts are becoming very expensive. So much is written today on rare books that is published widely and dealers are too smart to sell good things cheaply."

Some of the early books or portfolios of drawings and lithographs of the American Indians now sell for between $7,000 and $8,000 and are among the more valuable and desirable of early American historical books, according to Doctor Clarke.

Among the items in Doctor Clarke's collection are the only known copy of the first English-language New Testament printed west of the Alleghenies; the only known copy of a small pamphlet "On the Training and Education of Children," published in Cologne, Germany in 1533; a rare copy of the first history of Kentucky with the first story of Col. Daniel Boone, published in 1784; the first edition of "The Book of Mormon," by Joseph Smith, Jr., published in 1830; a rare book

(Continued on page 293)

Norman E. Clarke, MD, left, talks with Justin Schiller, noted children's books authority and rare book dealer from New York City. Mr. Schiller gave the dedicatory address at the opening of the Lucile Clarke Memorial Children's Library presented by Doctor Clarke to Central Michigan University in April, 1972.

Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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Chang Ho Youn, MD, 4160 John R, Detroit, 48201

DOCTOR CLARKE/Continued

containing the first map of the Oregon Trail; a sixth edition copy of "Tales of Passed Times by Mother Goose," one of the earliest in English and dated 1764; and a picture book for schoolchildren published first in America in 1810.

The Clarke Historical Library includes the 1833 copy of William Beaumont's "Experiments and Observations on the Gastric Juices and the Physiology of Digestion," done on Mackinac Island; and the pamphlet of the 1788 Marietta, Ohio ceremonies which opened the Northwest Territories to white settlers.

Doctor Clarke claims to have read since childhood "everything I could get my hands on with a particular interest in history. I just wanted to know the past," he says.

Doctor Clarke's greatest historical interest has been the Northwest Territory, the white man's expansion into the Ohio valley and later into the western United States.

He continues to add books, and other materials to the various collections in the Clarke Historical Library at Central Michigan University.

DOCTOR CARPENTER/Continued

brother, after he had shot the cub's mother not knowing she had young.

"Teddy was a clown," remembers Doctor Carpenter. "He could open any door and would stand up and turn around for a peppermint candy. After he was rewarded, you could ask him if he got the candy and he would stick out his tongue and show you."

The Carpenters love to tell about Teddy stealing his way into the house to take candy from the cupboards, then hooking his paw over the cupboard door and whining when it was all gone.

They tell about the time Teddy went swimming in the pond, climbed soaking wet into a friend's brand new Cadillac and would not get out until he was taken for a ride, as was his custom.

Or the time a pheasant hatched her brood on the Carpenter's bocce court, suspending play for the duration.

Well, you could go on and on about the Carpenters and their animals.

Update on Detroit General Hospital

By C. R. Shelton
Detroit

(Special to *Michigan Medicine)*

Planning and renovation possibly are the best words to describe the current status of Detroit General Hospital, the principal teaching facility for Wayne State University School of Medicine.

In May, 1972 an agreement was announced between the Detroit General Hospital Board of Trustees and the Board of Governors of Wayne State University to build a new Detroit General Hospital and the University Clinics on a joint site in the Medical Center.

A policy statement by both institutions emphasized mutual benefits of using a common base of operations. Paramount among the benefits is the elimination of duplicated services.

Plans call for the facilities to be built on an eight acre site south of Wayne State's Scott Hall, just north of Children's Hospital, east of the new Harper-Webber Hospital, and adjacent to the Chrysler Freeway.

Horace Sheffield, Detrtoit General's chairman of the board, announced the agreement and pointed out the benefits of the joint program. These include: minimizing duplicated facilities, such as laboratories and offices; reducing overall costs, both in initial construction and in operation; minimizing total space requirements; maximizing services and facilities which can be used in common and by other Medical Center institutions, and in some cases also Detroit General and the clinics using Detroit Medical Center units; and providing for the most advantageous movement of patients between the two facilities and other Medical Center components.

The two institutions are to be physically connected, but each unit will preserve its separate identity.

Later that year, it was announced that three architectural firms had joined together to provide professional services for the design of the proposed new Hospital and Clinics buildings. These firms began a feasibility study which continued design activities conducted earlier.

While various parts of the plan are being implemented, no money for construction of the new hospital is in hand. The City of Detroit has planning money allocated, but as yet none for building has been announced.

But Commissioner Roberts is confident that the new hospital will be a reality within five years, and some moves are being made accordingly.

One such move — in line with plans for the new Detroit General Hospital to be the Medical Center's major facility for emergencies and traumatic injuries — was the closing of Pediatric Ward 2-3 (patients through the age of 12) at the present hospital. Patients up to 13-years-old now are the responsibility of Children's Hospital.

Pediatric Ward 2-3 was closed to make room for the opening of the Crisis Intervention Center, and reflects the long-range program of reducing pediatric services at Detroit General as part of the overall redistribution of health care services furnished by Medical Center hospitals.

The Crisis Intervention Center is a new program for Detroit General and was planned initially for 10 patients. It is designed to give intensive five-day treatments to mentally ill patients who are expected to benefit from short-term therapy in contrast to long-term hospitalization.

Although the present location of Detroit General at 1326 San Antoine is extremely crowded and costly to maintain and renovate, improvements have been necessary for many reasons — including accreditation.

Among renovations initiated during the past three years are: complete renewal of the emergency room suite creating an observation room; total renovation of the pharmacy, along with its storage and processing areas; complete renovation of the radiology department and radiology suite waiting area as required by the accreditation body; a new nuclear medicine section and two special precedure rooms; and a new intensive care, coronary and burn unit.

But none of this cures one of Detroit General's greatest problems — space, or lack of it.

Currently the facility, which was created in 1915, has 488 beds. It has 388,000 gross square feet, including all corridors, closets, rooms, offices, wards and lobbies. Net space available is a little more than 261,000 square feet into which is crammed all the activities required by an acute care general hospital which also is a teaching institution.

Designs for the new Detroit General Hospital give the required 1,200 square feet per bed, or a total of 661,000 gross square feet for the planned 551 beds.

While everyone connected with Detroit General Hospital looks forward to the day — whenever it may be — that they occupy the new, modern building, their work goes on at the present location. It is antiquated and does not meet the requirements for a modern general hospital in terms of space and facilities. Yet the medical staff carries on there, delivering its usual service with dignity and excellence to patients, as well as operating an effective teaching program for medical students, interns and residents.

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Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (> 5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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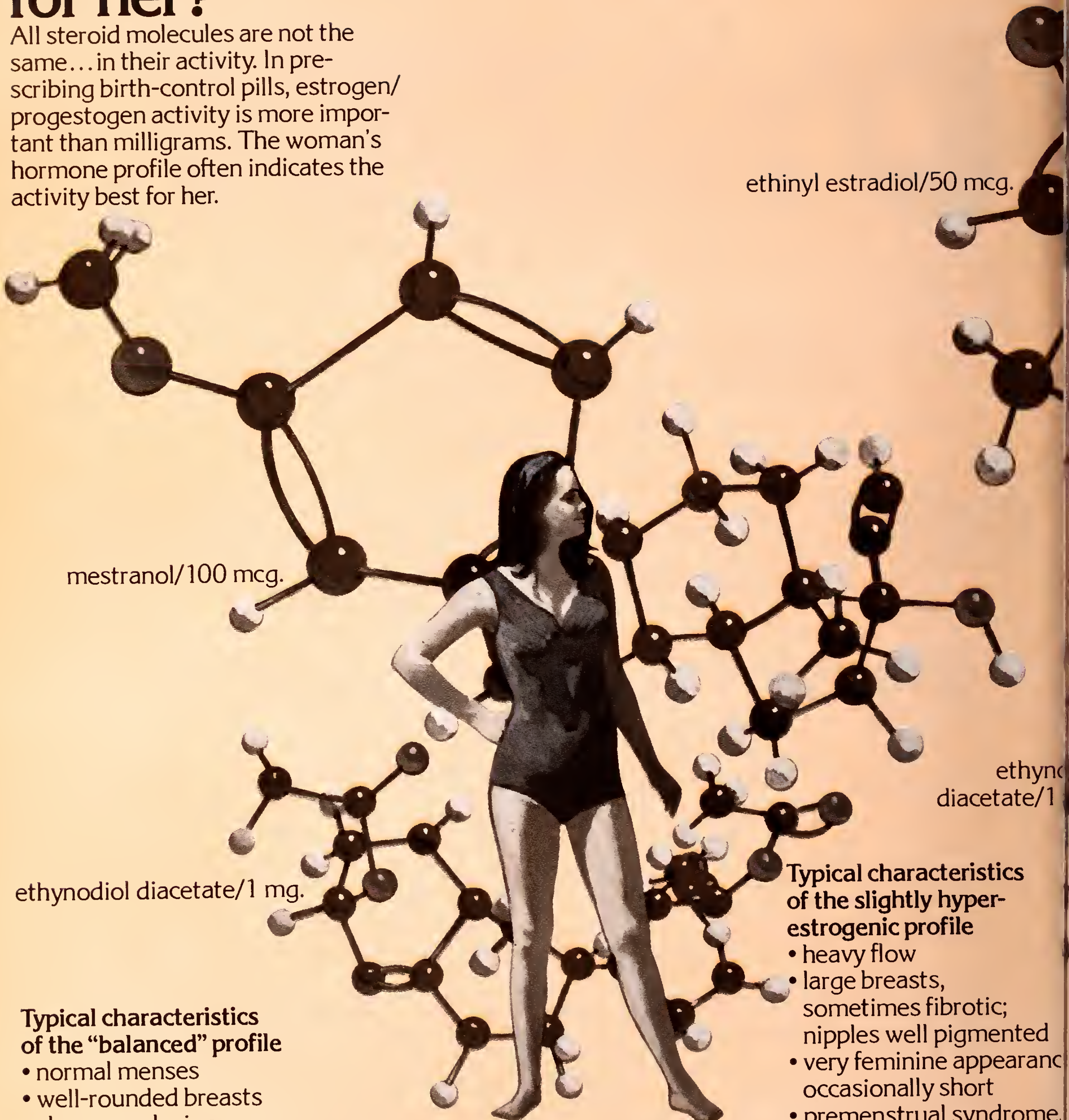

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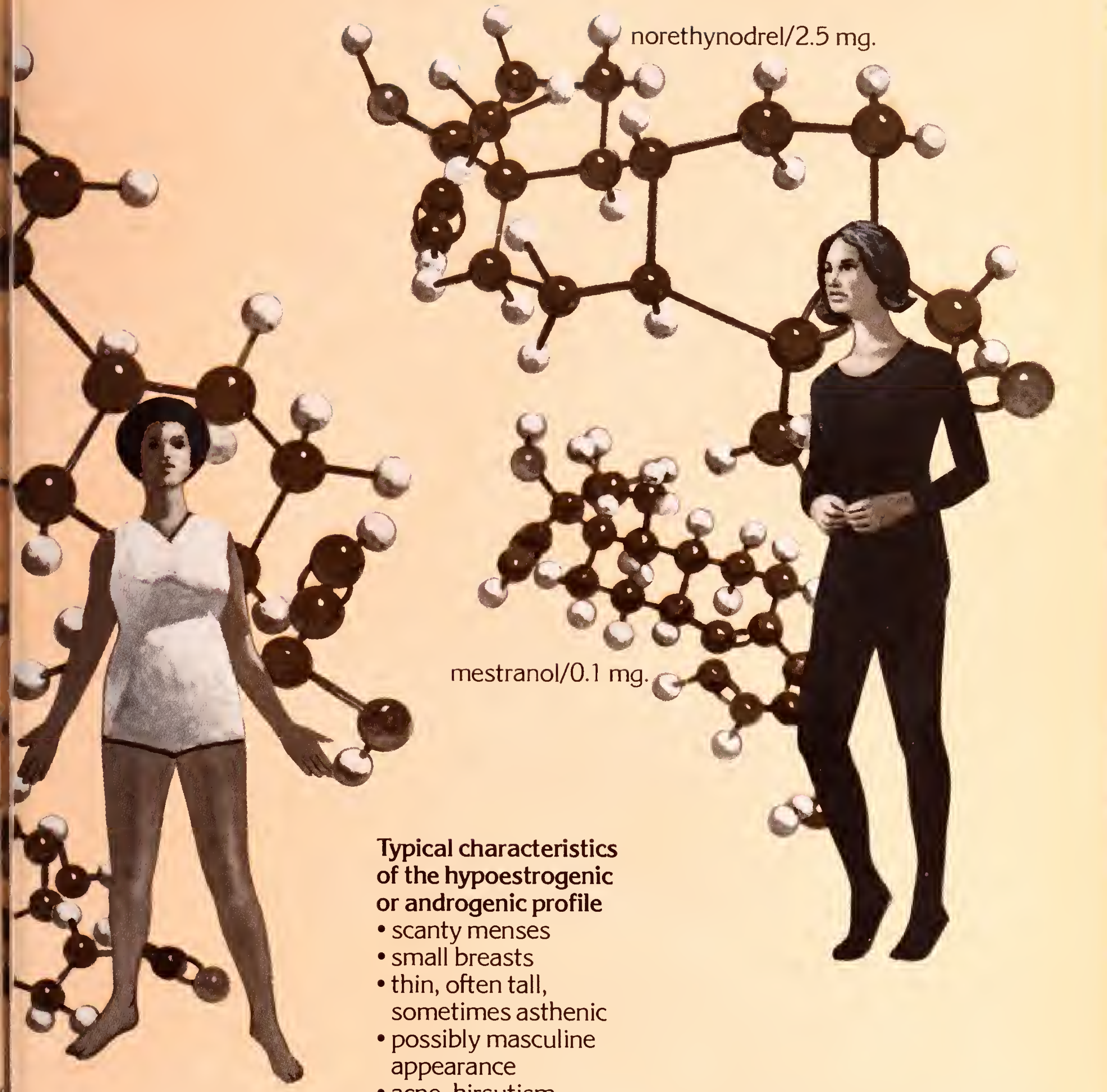
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- scanty menses
- small breasts
- thin, often tall, sometimes asthenic
- possibly masculine appearance
- acne, hirsutism
- low sexual motivation
- thin vaginal lining, tendency to vaginitis and dyspareunia

This pill has a relatively weak and unique* progestogen with inherent estrogenicity. Clinically, just as in animal studies, it appears not to possess antiestrogenic and androgenic activity.

)emulen®

able in 21- and 28-pill schedules
white tablet contains: ethynodiol
tate 1 mg./ethinyl estradiol 50 mcg.
pink tablet in Demulen-28® is a
bo containing no active ingredients.

l suited to most women
en low estrogenic activity
l moderate progestogen
ninance are preferred

Enovid-E®

Available in 20- and 21-pill schedules
Each tablet contains: norethynodrel
2.5 mg./mestranol 0.1 mg.

a clear choice for women when estrogen dominance and no androgenic activity are preferred

*Of all the progestogens, norethynodrel most resembles the molecular structure of the estrogens. It has the weakest progestational activity of any progestogen in a combination pill.

Ovulen®

Each white tablet contains:
ethynodiol diacetate 1 mg./mestranol 0.1 mg.

Demulen®

Each white tablet contains:
ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg.

Each pink tablet in Ovulen-28® and Demulen-28® is a placebo, containing no active ingredients.

Actions—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations pre-existing uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian adrenal, hepatic or uterine function awaits further study. A decrease ir glucose tolerance has been observed in a significant percentage o patients on oral contraceptives. The mechanism of this decrease i obscure. For this reason, diabetic patients should be carefully observe while receiving Ovulen or Demulen therapy. The age of the patient con stitutes no absolute limiting factor, although treatment with Ovulen o Demulen may mask the onset of the climacteric. The pathologist shoul be advised of Ovulen or Demulen therapy when relevant specimen are submitted. Susceptible women may experience an increase i blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral con traceptives—A statistically significant association has been demor strated between use of oral contraceptives and the following seriou adverse reactions: thrombophlebitis, pulmonary embolism and cere bral thrombosis.

Although available evidence is suggestive of an association, such relationship has been neither confirmed nor refuted for the followin serious adverse reactions: neuro-ocular lesions, e.g., retinal throm bosis and optic neuritis.

The following adverse reactions are known to occur in patient receiving oral contraceptives: nausea, vomiting, gastrointestinal symp toms (such as abdominal cramps and bloating), breakthrough bleedin spotting, change in menstrual flow, amenorrhea during and after trea ment, edema, chloasma or melasma, breast changes (tendernes enlargement and secretion), change in weight (increase or decrease changes in cervical erosion and cervical secretions, suppression c lactation when given immediately post partum, cholestatic jaundic migraine, rash (allergic), rise in blood pressure in susceptible individual and mental depression.

Although the following adverse reactions have been reported i users of oral contraceptives, an association has been neither co firmed nor refuted: anovulation post treatment, premenstrual-lik syndrome, changes in libido, changes in appetite, cystitis-like syndrom headache, nervousness, dizziness, fatigue, backache, hirsutism, loss c scalp hair, erythema multiforme, erythema nodosum, hemorrhagi eruption and itching.

The following laboratory results may be altered by the use of or contraceptives: hepatic function: increased sulfobromophthalein rete tion and other tests; coagulation tests: increase in prothrombin, Facto VII, VIII, IX and X; thyroid function: increase in PBI and butanol extrac able protein bound iodine, and decrease in T^3 uptake values; metyrapor test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Co traception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*:26 279 (May) 1967. **2.** Inman, W. H. W., and Vessey, M. P.: Investigation Deaths from Pulmonary, Coronary, and Cerebral Thrombosis an Embolism in Women of Child-Bearing Age, Brit. Med. J. 2:193-1 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relatic Between Use of Oral Contraceptives and Thromboembolic Disease. Further Report, Brit. Med. J. 2:651-657 (June 14) 1969. **4.** Sartwe P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromb embolism and Oral Contraceptives: An Epidemiologic Case-Contr Study, Amer. J. Epidem. *90*:365-380 (Nov.) 1969.

SEARLE
Products of **Searle & Co.**
San Juan, Puerto Rico 00936

Enovid-E®

with estrogen-dominant/ nonandrogenic activity

norethynodrel 2.5 mg./mestranol 0.1 mg.

Actions—Enovid-E acts to prevent ovulation by inhibiting the o put of gonadotropins from the pituitary gland. Enovid-E, depresses t output of both the follicle-stimulating hormone (FSH) and the lute izing hormone (LH).

Indication—Enovid-E is indicated for oral contraception.

The *Special Note, Contraindications, Warnings, Precautions* a *Adverse Reactions* listed above for Ovulen and Demulen are applica to Enovid-E and should be observed when prescribing Enovid-E.

Enovid-E®

brand of norethynodrel with mestranol

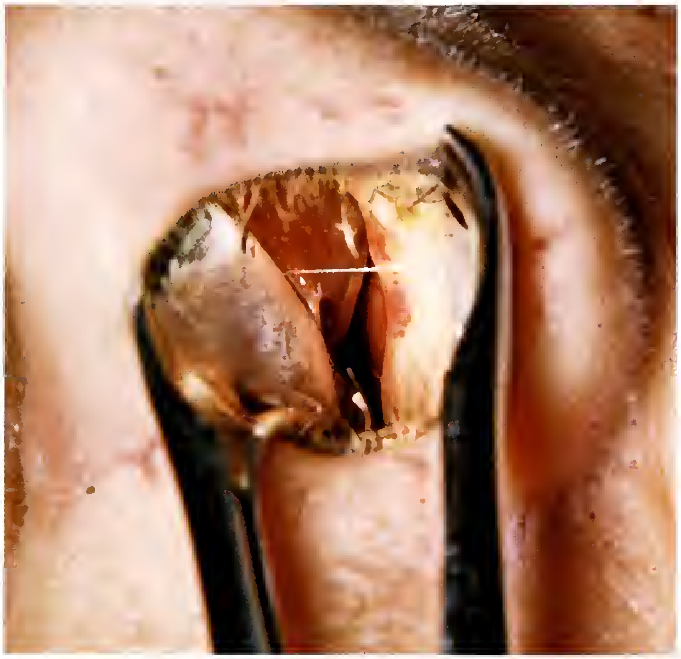
SEARLE
Product of **Searle Laboratories**
Division of G. D. Searle & Co.
Box 5110, Chicago, Illinois 60680
Where "The Pill" Began

Maybe the patient's self-diagnosis is right. He could have hay fever. But that bright red nasal mucosa, along with the thick discharge and excoriation around the nares, strongly suggests that the main problem is a cold. Hay fever or another form of allergic rhinitis may or may not be an underlying factor.

If a complete history and examination rule out allergic rhinitis, the long-term outlook will be a lot more favorable than his own "diagnosis" would have indicated.

But right now, whether he's got allergic rhinitis or a cold, he's suffering from the same irritating symptoms of drip, congestion and stuffiness. Try DIMETAPP EXTENTABS®. They're formulated to relieve these symptoms without much chance of causing drowsiness or overstimulation. Your patients will appreciate the 24-hour relief they can get from just one tablet every 12 hours.

Cold or



Allergy?

Whether it's a cold or an allergy, Dimetapp Extentabs® effectively relieve stuffiness, drip and congestion.

INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.
CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.
WARNINGS: *Use in children:* In infants and children [illegible] in overdosage may produce [illegible] and death.
PRECAUTIONS: [illegible] patients with [illegible] or hypertension. Until the patient's [illegible] he should be cautioned [illegible] in operations requiring [illegible] driving an automobile, operating machinery [illegible] additive effects with CNS depressants.

[illegible]
ADVERSE REACTIONS: [illegible]
[illegible]
HOW SUPPLIED: [illegible] bottles of 100 and 500.

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

A·H·ROBINS

[illegible]

when pain goes on... and on... and on–

For the patient with a terminal illness, PAIN past, present, and future can dominate his thoughts until it becomes almost an obsession. The more he is aware of the pain he is now experiencing, the more difficult it is to erase his memory of yesterday's pain, and to allay his fearful anticipation of tomorrow's pain.

Surely the last thing this patient needs is an analgesic containing caffeine to stimulate the senses and heighten pain awareness. A far more logical choice is Phenaphen with Codeine. The sensible formula provides ¼ grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can help control the pain more effectively. Don't you agree, Doctor, that psychic distress is an important factor in most of your terminal and long-term convalescent patients?

the analgesic formula that calms instead of caffeinates

Phenaphen® with Codeine

Phenaphen with Codeine No. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Codeine phosphate, ¼ gr. (No. 2), ½ gr. (No. 3) or 1 gr. (No. 4) (warning: may be habit forming).

Indications: Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions**: As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects**: Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

ⒸIII Phenaphen with Codeine is now classified in Schedule III, Controlled Substances Act of 1970. Available on written or oral prescription and may be refilled 5 times within 6 months, unless restricted by state law.

A. H. Robins Company, Richmond, Va. A·H·ROBINS

Latest MSMS survey shows physicians' costs still rising

Physicians' costs are continuing to rise faster than earnings according to the MSMS Bureau of Economic Information. The bureau's newly published report on the latest Overhead Cost Survey, carried out in 1972 on a basis of 1971 information reported by physicians, shows continuing increases in many of the goods and services required to run a medical practice.

The bureau's first Overhead Cost Survey, completed in 1971, measured changes over a five-year-period and found increases in costs disproportionately higher than increases in earnings.

"Continuation of the pattern can be seen in responses to the most recent survey," said John Anthony, director of the Bureau of Economic Information. "The earnings-to-revenue ratio reported for 1971 is 57.58 per cent, compared with 58.81 per cent for the previous year." Anthony estimated that the costs-and-earnings ratio continued to go downward in 1972, even though price and salary increases were subject to stringent federal controls during the latter part of the year.

Despite the end of most federal controls in January, physicians still face a limit of 2.5 per cent for increases in fees. The government has asked that increases in wages freed from controls voluntarily be limited to 5.5 per cent.

As a result of this, the average doctor finds himself having to pay more to keep his practice running smoothly while he cannot raise his fees enough to compensate for this difference, Anthony added. Thus, he finds his buying power significantly diminished in comparison to that of other wage earners, he added.

The Bureau of Economic Information reported that the greatest and most significant jumps in costs from 1970 to 1971 occurred in non-physician salaries, costs of drugs and medical supplies and laboratory charges. The survey report includes a breakdown on a basis of location in the state, type of practice and specialty of reporting physicians.

Information gathered by the Bureau of Economic Information through the Overhead Cost Survey and in other studies is being used by medical society leaders in supporting protests to the federal government about discrimination against physicians in Phase III price controls.

The survey results add to the Bureau of Economic Information's data bank which is becoming more and more important as a resource for the MSMS Council in deliberations over economic concerns. The data bank also is valuable to the Socio-Economic Committee, the Legislative Affairs Committee and the Relative Value Study Committee.

In the following exhibits and explanations, the extent of the rise in physicians' overhead costs, as shown in the survey, is fully illustrated.

HIGHLIGHTS OF FINDINGS

1. The cost-to-revenue ratio increased 1.23 percentage points from 41.19% to 42.42%. This is a 3.0% increase. This means the doctors' profit margin decreased 3% in 1971.
2. Salaries, payroll taxes, and fringe benefits comprise 45.6% of total costs in 1971, compared to 41.1% in 1970.
3. The largest percent increase in costs was the group containing drugs, medical supplies, and lab.
4. General practitioners had the largest cost-to-revenue margin (46.35%) in 1971. The surgical specialties had the lowest cost-to-revenue margin, and consequently the highest profit margin.
5. Incorporated practices had a higher cost-to-revenue ratio than unincorporated practices.
6. The five or more physician groups had the highest cost-to-revenue ratio in both 1970 and 1971.
7. The youngest age grouping had the lowest cost-to-revenue ratio. The oldest group had the highest cost-to-revenue ratio.

(Continued on next four pages)

MSMS cosponsoring social change symposium

MSMS is cosponsor along with the Departments of Psychiatry at Wayne State University and the University of Michigan of a symposium April 26 on "Social Change and the New Face of Medicine."

The symposium at the Raleigh House in Southfield is supported by the Geigy Pharmaceutical Company and will include discussions of no-fault medical liability insurance, ideals and practices of the medical scene, medical and philosophical insights on empty leisure, the limits of medicine and implications of social, political and economic change in medical practice during the next decades.

EXHIBIT I

Comparison Of Average Revenues, Costs, and Earnings For All Respondents

	ALL RESPONDENTS 1970	ALL RESPONDENTS 1971	PERCENT INCREASE (DECREASE)	RESPONDENTS WITH FULL COST DETAIL 1971	PERCENT INCREASE (DECREASE)
Number of Respondents	557	769	38.1%	694	24.6%
Cost to Revenue Ratio	41.19%	42.42%	3.0%	42.68	3.6
Earnings to Revenue Ratio	58.81%	57.58%	(2.1)	57.32	(2.5)

EXHIBIT II

COST CATEGORY DEFINITIONS
Michigan State Medical Society
1971

1. *NON-OWNER PHYSICIAN SALARIES:* Salaries of physician employees who do not own any portion of the practice.
2. *NON-PHYSICIAN SALARIES:* Salaries of employees who are not physicians.
3. *PAYROLL TAXES AND FRINGE BENEFITS:* Cost of F.I.C.A., unemployment taxes, hospitalization, bonuses, group life insurance, group disability, pensions and other benefits. (Does not include owner pension)
4. *DRUGS, MEDICAL SUPPLIES, AND LABORATORY FEES*
5. *OCCUPANCY, EQUIPMENT AND OFFICE:* Includes rentals, depreciation, property taxes, utilities, telephone, maintenance, office supplies, postage, and laundry.
6. *INSURANCE:* Professional and general liability, fire and business insurance (does not include life insurance).
7. *AUTOMOBILE:* Cost of auto lease, depreciation, gas and maintenance.
8. *OTHER:* Includes donations, conventions, dues, journals, entertainment, legal and accounting fees, and locum tenens.

EXHIBIT III

COMPARISON OF COST ELEMENT DETAIL

	COST ELEMENTS BY PERCENT OF REVENUE 1970	COST ELEMENTS BY PERCENT OF REVENUE 1971	COST ELEMENTS BY PERCENT OF TOTAL COST 1970	COST ELEMENTS BY PERCENT OF TOTAL COST 1971
REVENUE				
COSTS:				
Non-owner physician salaries	1.6%	1.7%	3.9%	4.1%
Non-physician salaries	12.4%	14.7%	30.0%	34.4%
Payroll taxes and fringe benefits	2.9%	3.0%	7.2%	7.1%
Drugs, medical supplies and lab	6.2%	7.4%	15.2%	17.3%
Occupancy, equipment and office	10.4%	8.2%	25.2%	19.3%
Insurance	2.4%	2.2%	5.8%	5.1%
Automobile	1.8%	1.2%	4.3%	2.9%
Other cost	3.5%	4.2%	8.4%	9.8%
	41.2%	42.6%	100.0%	100.0%

(Continued on page 304)

Placidyl®
(ETHCHLORVYNOL)

Brief Summary

Indications—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

Contraindications—Drug hypersensitivity and porphyria.

Warnings—Not recommended during the first and second trimester of pregnancy. Caution patients of possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

Precautions—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitryptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

Adverse Reactions—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 304431

Give us his nights.

Prescribe Placidyl. Chances are, we'll give him a good night's sleep.

Insomnia may often accompany surgical convalescence. During those long nights following surgery, sleep can be as elusive as it is vital.

When sleep is synonymous with therapy, remember . . . Placidyl is synonymous with sleep. It has been for over 17 years.

If time is the criterion to inspire your confidence . . . you can rest assured with Placidyl.

Prescribed by physicians for over 17 years.

Placidyl® Ⓒ IV

(ETHCHLORVYNOL CAPSULES, 500 or 750 mg.)

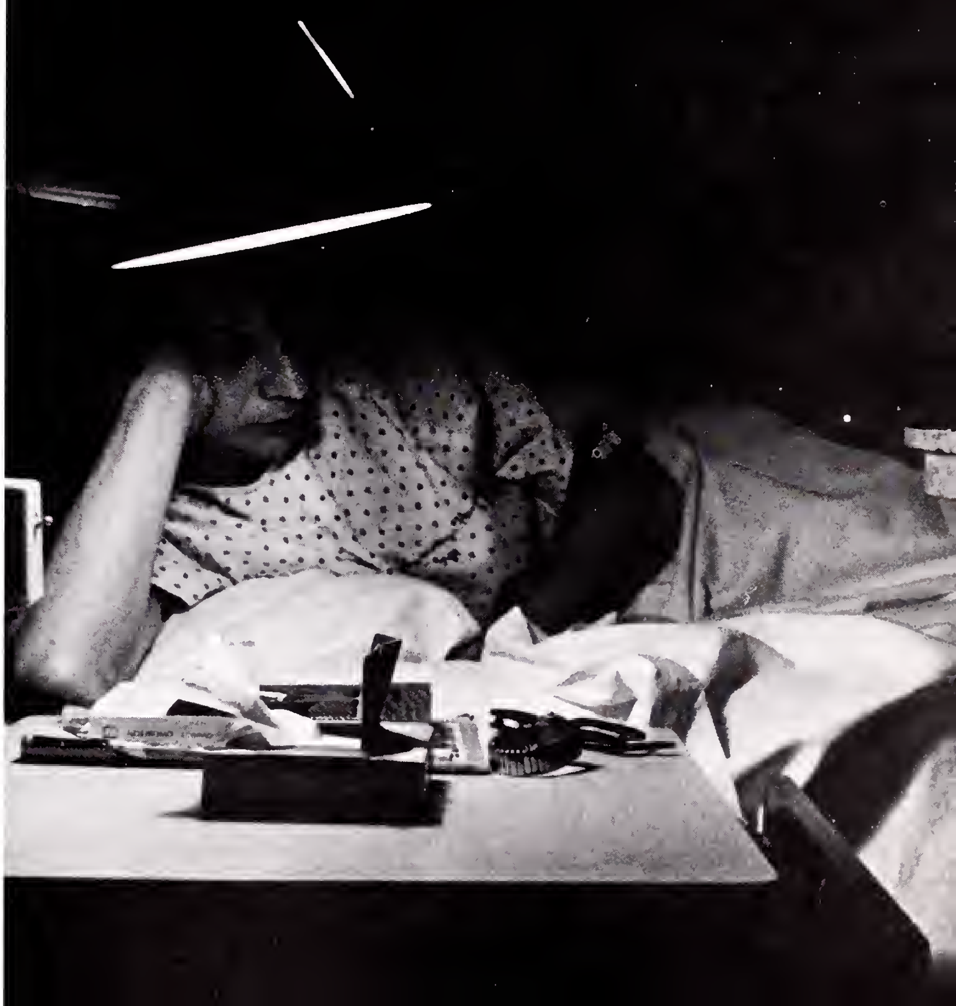


EXHIBIT IV

Specialty Grouping Designations

General Practice

General Practice

Medical Specialties

Allergy
Dermatology
Gastroenterology
Internal Medicine
Pediatrics

Surgical Specialties

Surgery
Neurological Surgery
Obstetrics and Gynecology
Ophthalmology
Orthopedic Surgery
Otolaryngology
Plastic Surgery
Proctology
Thoracic Surgery
Urology

Other Specialties

Anesthesiology
Neurology
Psychiatry
Pathology
Physical Medicine
Radiology
Unspecified

EXHIBIT VI

Geo-Economic Area Designations

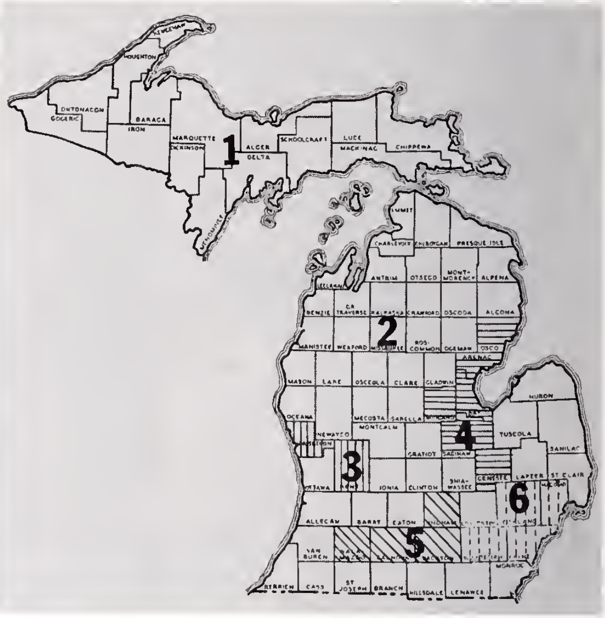

KEWEENAW
HOUGHTON
ONTONAGON
GOGEBIC
BARAGA
IRON
MARQUETTE
DICKINSON
1
ALGER
DELTA
SCHOOLCRAFT
LUCE
MACKINAC
CHIPPEWA
MENOMINEE
EMMET
CHARLEVOIX
CHEBOYGAN
PRESQUE ISLE
ANTRIM
OTSEGO
MONT-MORENCY
ALPENA
LEELANAU
BENZIE
GR TRAVERSE
KALKASKA
CRAWFORD
OSCODA
ALCONA
2
MANISTEE
WEXFORD
MISSAUKEE
ROS-COMMON
OGEMAW
IOSCO
ARENAC
MASON
LAKE
OSCEOLA
CLARE
GLADWIN
HURON
OCEANA
MECOSTA
ISABELLA
MIDLAND
BAY
NEWAYGO
MONTCALM
4
TUSCOLA
SANILAC
MUSKEGON
3
GRATIOT
SAGINAW
OTTAWA
KENT
IONIA
CLINTON
SHIA-WASSEE
GENESEE
LAPEER
ST CLAIR
6
MACOMB
ALLEGAN
BARRY
EATON
INGHAM
OAKLAND
VAN BUREN
KALAMAZOO
CALHOUN
5
JACKSON
WASHTENAW
WAYNE
MONROE
BERRIEN
CASS
ST JOSEPH
BRANCH
HILLSDALE
LENAWEE

EXHIBIT V

Trends In Average Revenue, Costs And Earnings By Specialty Groupings

	RATIO: COST TO REVENUE		RATIO: EARNINGS TO REVENUE	
SPECIALTY GROUP	1970	1971	1970	1971
GENERAL PRACTICE	43 84	46.35	56.16	53.65
MEDICAL SPECIALTIES				
Internal Medicine	40.41	41.72	59 59	58.28
Pediatrics	38.99	44.19	61.01	55.81
Other Medical Specialties	43 49	45.87	56.51	54.13
Total	40.48	42.70	59.52	57.30
SURGICAL SPECIALTIES				
Surgery	34.43	37 03	65.57	62.97
Obstetrics & Gynecology	37.77	36.12	62.22	63.88
Other Surgical Specialties	42.25	43.14	57.74	56.86
Total	38.57	39.50	61.43	60.50
OTHER SPECIALTIES	41.59	43.67	58.40	56.33
TOTAL GROUP	41.19	42.42	58.81	57.58

(Continued on page 306)

Must vasodilators and therapy for other diseases come into conflict?

not if the vasodilator is

VASODILAN®

(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

© 1973 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. 734017

Mead Johnson LABORATORIES

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[1] Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

EXHIBIT VII

Trends In Average Revenue, Cost and Earnings By Geo-Economic Groupings

GROUP	COUNTIES	RATIO: COST TO REVENUE 1970	RATIO: COST TO REVENUE 1971	RATIO: EARNINGS TO REVENUE 1970	RATIO: EARNINGS TO REVENUE 1971
1	Upper Peninsula Counties	41.93	45.62	58.07	54.38
2	Other Lower Peninsula Counties	40.99	44.49	59.01	55.51
3	Muskegon & Kent	42.16	40.82	57.83	59.18
4	Bay-Midland-Saginaw-Genesee-Arenac-Iosco	46.86	39.67	53.13	60.33
5	Kalamazoo-Calhoun-Jackson-Ingham	38.11	41.21	61.89	58.79
6	Washtenaw-Wayne-Oakland-Macomb	39.75	42.03	60.24	57.97
	Unspecified	34.30	51.46	65.70	48.54
TOTAL GROUP		41.19	42.42	58.81	57.58

EXHIBIT VIII

Average Cost Comparisons By Form Of Practice

FORM OF PRACTICE	RATIO: COST TO REVENUE 1970	RATIO: COST TO REVENUE 1971
SOLO PRACTICES:		
Incorporated	40%	41%
Unincorporated	41%	40%
GROUP PRACTICE:		
Incorporated	45%	46%
Unincorporated	37%	40%
TOTAL	41%	42%

EXHIBIT IX

Average Cost Comparisons By Size Of Practice

NUMBER OF PHYSICIANS IN PRACTICE	COST TO REVENUE 1970	COST TO REVENUE 1971
1 Physician	41%	40%
2-4 Physicians	40%	41%
5 or more Physicians	52%	51%
TOTALS	41%	42%

(Continued on Page 308)

Dear Doctor:

This month's "Bio-Science Reports," on the page opposite, is another service of Bio-Science Laboratories.

From time to time, you'll be seeing different reports in Michigan Medicine dealing with laboratory medicine as it applies to your clinical practice.

Over the past 25 years, physicians such as yourself have found that our laboratory service provides a continuing source of accurate results and helpful literature.

Please use the coupon at the bottom of the "Bio-Science Reports" to request any information about our services, fees, or free starter materials.

We are looking forward to serving you.

Sincerely,

Donald C. Cannon

Donald C. Cannon, M.D., Ph.D.
Director

25 YEARS

Bio-Science Laboratories

Bio-Science Reports

The Venereal Disease Epidemic:

How To Use The Laboratory

In our newly revised "Laboratory Aid" (see below) devoted to diagnosis and treatment of syphilis and gonorrhea we quote Dr. Sidney Olansky: "Therefore, we have reached the point where the serologic problems associated with syphilis almost always can be resolved with the proper use of two tests: the VDRL slide test and the FTA-ABS test." ("Serodiagnosis of Syphilis" in The Medical Clinics of North America *56*:1145, 1972.) From our broad experience in laboratory services devoted to the diagnosis and follow-up of syphilis we know that the "almost always" part of Dr. Olansky's statement describes those situations which are most troublesome to physicians.

The VDRL test is somewhat insensitive in very early syphilis. Thus the FTA-ABS test, not ordinarily considered a screening procedure, may sometimes be the test of choice in those instances when the physician suspects early syphilis in the face of a "Non-reactive" VDRL test.

When a diagnosis of syphilis has been made, the efficacy of treatment should be checked by *periodic quantitative VDRL tests*—not by the FTA-ABS test, which may remain reactive for life even in cured syphilis.

False positive VDRL tests are usually transient and of low titer. If reactivity persists, the clinician should suspect an underlying "auto-immune" disturbance, perhaps SLE. Although not as frequent, false positive FTA-ABS tests also occur, usually because there is another disease nvolved; however, final resolution may not be possible until autopsy, if at all. The question of whether or not to start antibiotic therapy becomes strictly a clinical decision.

A recently described modification of the FTA test using CSF is available from our laboratory and may be of help or physicians faced with the possibility of neurosyphilis n older patients with *sero*-negative VDRL and reactive FTA-ABS tests. (Brit. J. Ven. Dis. *48*:97, 1972.)

Some Words on Gonorrhea

Unfortunately, a simple inexpensive screening test analogous to the VDRL is not yet available for gonorrhea. Transgrow Collection Kits make the services of our reference laboratory available to any physician seeking "bacteriological" confirmation of GC.

The Complement Fixation test for *N. gonorrhoeae* may be of value in uncovering "hidden" GC in the relatively asymptomatic female and in the Asian variety of gonorrhea.

In Summary

Bio-Science Laboratories offers an exceptionally complete array of tests to aid in the diagnosis of both syphilis and gonorrhea; our new booklet, "Laboratory Aids for the Diagnosis and Treatment of Gonorrhea and Syphilis," is available at no cost or obligation to guide clinicians in the selection of the appropriate tests and in the interpretation of test results.

Pertinent Tests Available at Bio-Science Laboratories

VDRL, qualitative, quantitative, and pre-marital
FTA-ABS
FTA, modified, for cerebrospinal fluid
Darkfield examination (local clients)
Direct FA stain for *T. pallidum*
(for mailed specimens)
Gram stain and/or FA stain for *N. gonorrhoeae*
Complement-fixation Test for antibodies to
N. gonorrhoeae
Routine culture for GC (local clients)
Transgrow Collection Kit for GC cultures
(for mailed specimens)

Bio-Science Laboratories

Main Lab: 7600 Tyrone Ave.
Van Nuys, California 91405
Philadelphia Branch:
116 So. Eighteenth St.
Philadelphia, Pa. 19103

Bio-Science Laboratories
7600 Tyrone Avenue
Van Nuys, California 91405 Dept. W
Philadelphia Branch:
116 So. Eighteenth St.
Philadelphia, Pa. 19103

FREE! Laboratory Aids for the Diagnosis and Treatment of Gonorrhea and Syphilis

Gentlemen: Please send me—

☐ A copy of your booklet on LABORATORY AIDS FOR THE DIAGNOSIS AND TREATMENT OF GONORRHEA AND SYPHILIS.

☐ A STARTER LAB PACK containing a small supply of postage-paid mailing containers and FEE SCHEDULE.

Name

Address

City State Zip

Laboratory Aids for the Diagnosis and Treatment of Gonorrhea and Syphilis

This 12-page booklet, written by Drs. Olitzky and Blaker of the staff of Bio-Science Laboratories, contains a clear and graphic summary of the value and limitations of laboratory technics in the assessment of these venereal disease problems. You will find it to be a quick and ready reference to update yourself in this important area of laboratory medicine. Copies are available to physicians and lab personnel without obligation. Simply fill out and mail this coupon.

EXHIBIT X

Average Cost Comparisons By Physician Age Groupings

PHYSICIAN AGE GROUP	PER CENT PHYSICIANS IN GROUP 1970	PER CENT PHYSICIANS IN GROUP 1971	RATIO: COST TO REVENUE 1970	RATIO: COST TO REVENUE 1971
35 and Below	6%	9%	41%	40%
36 - 45	31%	28%	42%	41%
46 - 55	32%	30%	40%	41%
56 - 65	22%	18%	41%	42%
Over 65	8%	8%	48%	47%
Unclassified	1%	7%	37%	54%
TOTALS	100%	100%	41%	42%

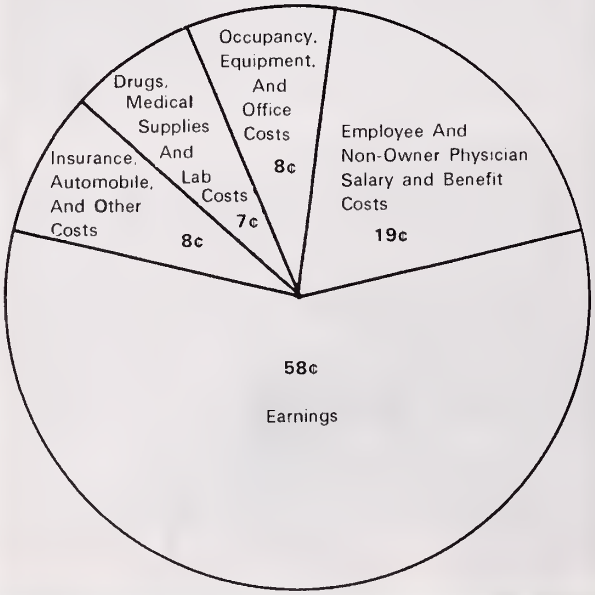
EXHIBIT XI

Average Cost Comparisons By Weekly Medical Practice Hours

GROUPS BY HOURS PER WEEK	PER CENT PHYSICIANS IN GROUP 1970	PER CENT PHYSICIANS IN GROUP 1971	RATIO: COST TO REVENUE 1970	RATIO: COST TO REVENUE 1971
40 Hours or Below	20%	21%	43%	45%
41 - 50 Hours	24%	25%	45%	44%
51 - 60 Hours	32%	35%	40%	42%
61 - 70 Hours	17%	14%	36%	40%
71 - 80 Hours	5%	3%	46%	33%
Over 80 Hours	2%	2%	42%	40%
TOTAL	100%	100%	41%	42%

EXHIBIT XII

Distribution Of The Average Medical Practice Revenue Dollar



new Santyl™ ointment (collagenase)

Indications: Santyl Ointment is indicated for debriding dermal ulcers and severely burned areas. In other types of necrotic skin lesions reports on the use of Santyl Ointment have been limited to clinical observations without controls.

Contraindications: Application is contraindicated in patients who have shown local or systemic hypersensitivity to Collagenase.

Precautions: The enzyme's optimal pH range is 7 to 8. Lower pH conditions have a definite adverse effect on the enzyme's activity, and appropriate precautions should be taken.

The enzymatic activity is also adversely affected by detergents and hexachlorophene and heavy metal ions such as mercury and silver which are used in some antiseptics. When it is suspected such materials have been used, the site should be carefully cleansed by repeated washings with normal saline before Santyl Ointment is applied. Soaks containing metal ions or acidic solutions such as Burow's solution should be avoided because of the metal ion and low pH. Cleansing materials such as hydrogen peroxide or Dakin's solution do not interfere with the activity of the enzyme.

Debilitated patients should be closely monitored for systemic bacterial infections because of the theoretical possibility that debriding enzymes may increase the risk of bacteremia.

The ointment should be confined to the area of the lesion in order to avoid the risk of irritation or maceration of normal skin.

A slight erythema has been noted occasionally in the surrounding tissue particularly when the enzyme ointment was not confined to the lesion. This can be readily controlled by protecting the healthy skin with a material such as Lassar's paste.

Since the enzyme is a protein, sensitization may develop with prolonged use although none has been observed to date.

Adverse Reactions: Adverse reactions to Collagenase have not been noted when used as directed.

Dosage & Administration: Santyl Ointment should be applied once daily (or once every other day in the case of outpatients) in the following manner.

(1) Prior to application the lesions should be gently cleansed with a gauze pad saturated in normal saline, buffer (pH 7.0-7.5) or hydrogen peroxide to remove any film and digested material.

(2) Whenever infection is present, as evidenced by positive cultures, pus, inflammation or odor, it is desirable to use an appropriate topical antibacterial agent. Neomycin-Bacitracin-Polymyxin B (Neosporin) has been found compatible with Santyl Ointment. This antibiotic should be applied to the lesion in powder form or solution prior to the application of Santyl Ointment. Should the infection not respond, therapy with Santyl Ointment should be discontinued until remission of the infection.

(3) Santyl Ointment should be applied (using a wooden tongue depressor or spatula) directly to deep wounds, or, when dealing with shallow wounds, to a sterile gauze pad which is then applied to wound. The wound is covered with sterile gauze pad and secured with clear tape or Kling bandage.

(4) Crosshatching thick eschar with a #11 blade is helpful. It is also desirable to remove as much loosened detritus as can be done readily with forceps and scissors.

(5) All excess ointment should be removed each time dressing is changed.

(6) Use of the ointment should be terminated when sufficient debridement of necrotic tissue has taken place.

Overdose: Action of the enzyme may be stopped, should this be desired, by the application of Burow's solution U.S.P. (pH 3.6-4.4) to the lesion.

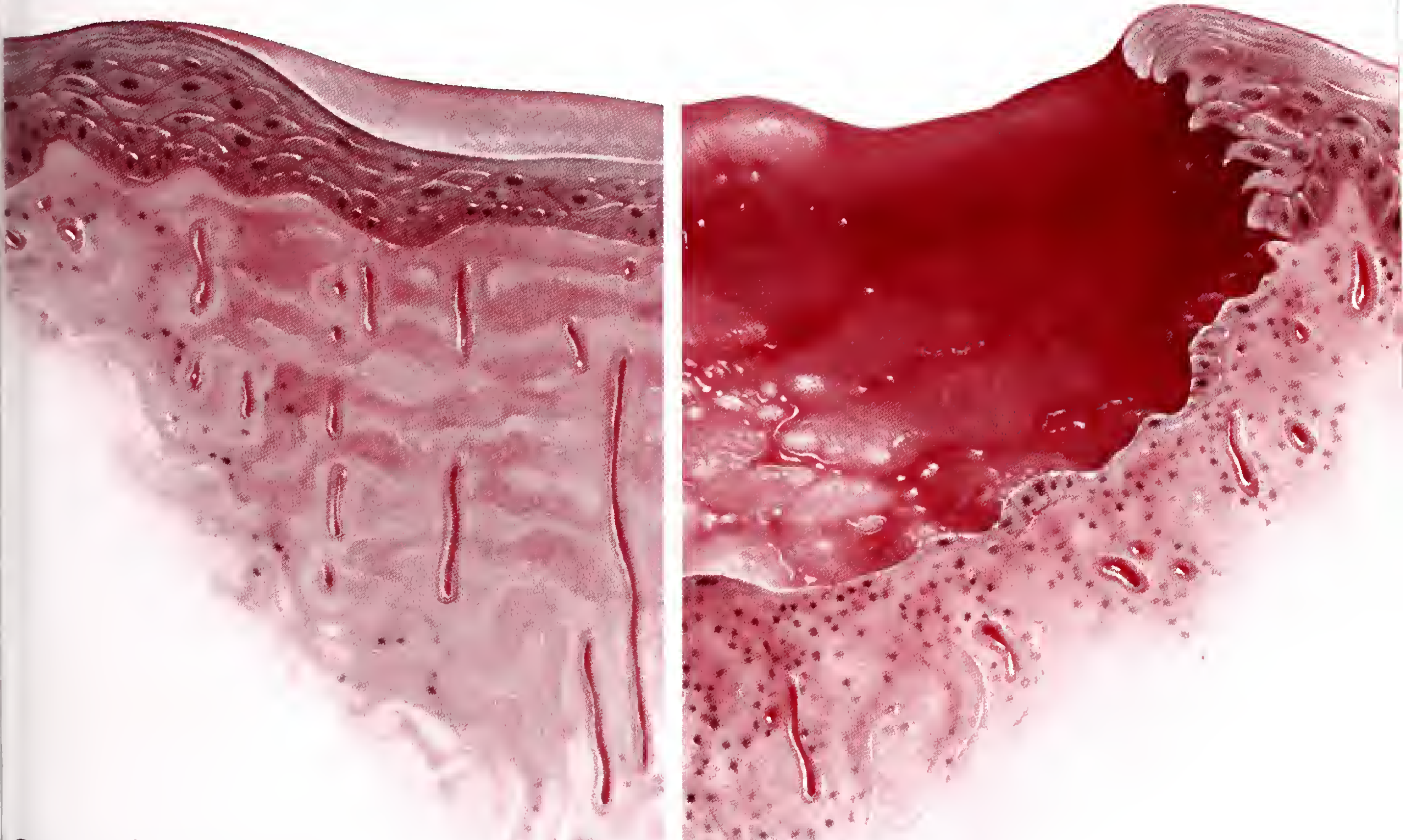
How Supplied: Santyl Ointment contains 250 units of Collagenase enzyme per gram of white petrolatum U.S.P. The potency assay of Collagenase is based on the digestion of undenatured collagen (from bovine Achilles tendon) at pH 7.2 and 37° C. for 24 hours. The number of peptides cleaved are measured by reaction with ninhydrin. Peptides released by a trypsin digestion control are subtracted. One net Collagenase unit will solubilize ninhydrin reactive material equivalent to 4 micromoles of Leucine.

Knoll Pharmaceutical Co.
30 North Jefferson Road
Whippany, New Jersey 07981

new
Santyl™
ointment
(collagenase)

"...it may prove to be the drug of choice for wound debridement."
Varma A O et al: *Surg. Gynec. Obstet.* 136:281, Feb. 1973.

To permit healing like this...you want to start like this.



Artist's conception of decubitus ulcer

Santyl™ (collagenase) for dermal ulcers and burns: the first topical enzyme

- **to attack** native collagen, a substance that is ordinarily resistant to all common topical enzymes used in wound debridement
- **to dissolve** the strands of tissue that "anchor" necrotic debris and burn eschar to the wound surface
- **to effectively remove** the debris that hinders healing...with simple, once-a-day application

I treat patients with dermal ulcers and burns, and I would like to receive:
☐ clinical reprints and scientific information on Santyl.
☐ a free in-service training program on the use of Santyl.

Name
Nursing home or hospital affiliation
Office address
City State Zip code

MSMS potpourri

The Michigan Council of Specialty Societies, formed in 1970 by then MSMS President Harold H. Hiscock, MD, Flint, continues to meet to promote better cooperation and understanding between the specialty societies of the state. Among the topics at a recent meeting, led by Moderator Glenn E. Moore, MD, at head of table, were a report on major MSMS public relations projects for 1973, a progress report on the Medicaid Liaison Committee negotiations with the Governor's office, and formation of a postition statement on reimbursement for pre and post-operative care.

Robert M. Stow, MD, far left, led the Council of Specialty Societies' discussion of the malpractice situation in Michigan, the subject of a CSS study committee's evaluation. Doctor Stow was flanked, from left, by James H. Saker, MD, Lansing, representing the allergists; Robert J. Crossen, MD, Grosse Pointe Woods, ophthalmologist, and Watson A. Gilpin, MD, Troy, chest physician.

Dale Drew, MD, left, president of the Oakland County Medical Society, discusses details of the new MSMS insurance benefits program for interns and residents with William Cheeseman, right, representative of the Ben Stratton Agency, Lansing, administrators for the MSMS group insurance programs. Recently, interns and residents in Oakland County joined the Oakland component society and MSMS and enrolled in the new group disability and group life programs. Interested interns and residents must be associate or active members of the component society and MSMS to be eligible. Details may be obtained from the MSMS Department of Member Services.

The MSMS Judicial Commission has welcomed two new members to its ranks and elected a new chairman and vice chairman. Gathered at a recent meeting, they are Robert J. Mason, MD, Birmingham, seated, new chairman; and from left, William C. Baum, MD, Holland, and John W. Grigg, MD, Bay City, new members, and Justin L. Sleight, MD, Lansing, new vice chairman.

vertisement

> *"The history of science, and in particular the history of medicine . . . is . . . the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."*
>
> *—George Sarton, from "The History of Medicine Versus the History of Art"*

Are there significant differences in bioavailability and clinical predictability among drug products?

Opinion

Results of a questionnaire to 7,000 physicians:

44.6%
Agree there is a significant difference

24.9%
Believe there is no difference

30.5%
Had no opinion

Are there significant difference
in bioavailability and clinica
predictability among drug products

Teacher of Medicine

Alfred Gilman, Ph.D.
Wm. S. Lasdon
Professor & Chairman
Department of
Pharmacology
Albert Einstein
College of Medicine of
Yeshiva University

I think that there can be a very great distinction between generic drugs and brand name drugs. And that applies to products of original research that have outlived their patent protection as well as to drugs that have long been in the public domain. Let me explain why.

The Importance of the Manufacturing Environment

In terms of formulation, quality control, and the ability to reproduce an essentially identical product, batch after batch, I doubt that many firms are properly equipped to put out a product that is as carefully controlled as the product marketed by a pharmaceutical company with sophisticated research and high quality manufacturing facilities. For example, when a company comes out with its own preparation of a drug that has just lost its patent protection, there is no assurance that the drug it produces will be a therapeutic equivalent. The raw material could be identical and yet bioavailability might vary from complete unavailability to that which is equivalent to the original.

It Isn't Enough to Meet USP and NF Standards

Meeting USP and NF standards is not enough to guarantee therapeutic equivalence. In certain instances, stricter standards must be applied. Right now, the New York Heart Association has a committee that is studying the problem of digoxin equivalency. I am certain that they are going to recommend a bioavailability assay of a particular digoxin. Unless this is done, they will not recommend it for purchase or use in New York City hospitals. It represents too much of a hazard. They have gone so far as to recommend a batch-by-batch certification of bioavailability even though the company has been reproducing and marketing a digoxin product through the years.

The Problem of Controlling Bioavailability of Generics

The FDA does not have the manpower to inspect the quality control capabilities of hundreds of houses specializing in generic products. And I don't think that the average pharmacist is knowledgeable or aware of the quality and bioavailability of the infinite numbers of generic preparations. A recommendation has been made that every time a generic house (or for that matter a large pharmaceutical company) markets an already existing drug for the first time, a modified new drug application should be submitted. The manufacturer would have to show that his compound is the therapeutic equivalent of the standard compound in use, assuming that the standard compound is one that has been available for an extended period—say 15 years. This would be one indication that the control of bioavailability is beginning to get the attention that it deserves.

Clinical Predictabilit
More Important Than P

Although the questio
price has been greatly
aggerated, it is true t
patients can on occas
save money on gen
drugs. But you are not
ing to dare attempt to s
money if it jeopardizes
patient's health. Let's
turn to the example t
has become very promi
in recent years, that of
cardiac glycosides. T
are probably the most t
drugs we use with res
to the small difference
tween a maximally effec
dose and a toxic dose. W
you are dealing with d
of this type, the first
cern must be clinical
dictability. At the ris
variations in bioavail
ity, it would be sheer
to try to save the pat
what might amoun
maybe $10 or $20 a
The physician cannot
age his patient unless
sure that the drug h
prescribing has the
positive effect each
the prescription is rene
This is especially sig
cant when the patient t
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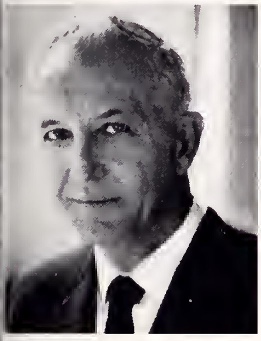
but for the rest of his l

Maker of Medicine

C. J. Cavallito, Ph.D.
ecutive Vice President
Ayerst Laboratories



lthough equivalence of
erent preparations of a
g *substance* may be de-
d by certain physical,
mical or biological char-
ristics, identity is not
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be produced by differ-
manufacturers such
these products are bio-
cally or therapeutically
uivalent.

Growing Awareness of Potential for Nonequivalence

s experience increases
drug substances de-
d from different sources
under different condi-
s, it should be possible
stablish specifications in
icient detail to minimize
potential for their non-
ivalence. However,
e is general agreement
t product therapeutic
ivalence would still not
ssured even if one could
minimize nonequivalence of drug components produced by different manufacturers. Arguments relate largely to the extent of product inequivalences. Experience over the past six years has uncovered a greater incidence of nonequivalence of products prepared by different manufacturers from generically equivalent substances than many had previously surmised.

Newer Bioavailability Studies Reveal Differences

Bioavailability may be defined as a measure of the rate and amount of absorption of a drug substance from its administered dosage form. For several years pharmaceutical scientists have proposed that bioavailability data on presumably equivalent dosage forms provide the best measure of product equivalence—short of adequate clinical trial. In their continued search for shortcuts to the evaluation of product equivalence, medical and pharmaceutical scientists have increasingly relied upon bioavailability characteristics as reflected by blood levels of a drug after its administration to human subjects.

Leading manufacturers now conduct comparative bioavailability studies on their own product dosage forms after production process changes that would have been considered inconsequential a few years ago. This isn't surprising, since there are so many possible differences in production operations that the opportunities for inequivalent generic and brand name products are numerous—even when the production process begins with identical chemical substances. Moreover, reputable manufacturers are striving to improve *in vitro* control measures, such as dissolution characteristics, which are being related more meaningfully to bioavailability reference data.

As a result of advances in scientific instrumentation and analytical methodology which permit measurements of small quantities of drug substances in the body, our abilities to detect differences in bioavailability and possible therapeutic nonequivalance have appreciably improved.

Product Selection Based on Patient Response

Improved specifications and standards can better assure the equivalence of *drug substances*. Manufacturers, compendia and regulatory agencies can all play a part. However, it is the *drug product*, not the *drug substance*, that the physician, pharmacist, nurse and patient-customer utilize. How can these individuals make or influence specific product selections to minimize variations in therapeutic equivalence of multisource drugs? Patients' responses to a drug product provide a basis of experience to aid the physician in his selection of a particular product. The nurse and pharmacist can also help detect patient responses, but ultimate responsibility must remain with the physician.

Reputation of Manufacturer as Basis for Product Selection

The physician, to assure that his patients receive quality health care, must rely upon the capabilities of the reputable pharmaceutical manufacturer who is equipped to develop, prepare and control a quality product of uniform, reliable therapeutic performance. Substitution with purportedly equivalent generic products that are only superficially evaluated by an imitator manufacturer can place the health of the patient secondary to factors of price or convenience for the provider.

Opinion & Dialogue

What is your opinion, doctor?
We would welcome your comments.

P·M·A

The Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

Integument!

Our skin—the human integument—covers us, defines us, protects us. But skin is subject to cuts, burns, abrasions. And infections. Neosporin Ointment fights infection by providing broad antibacterial action against susceptible skin invaders. It contains antibiotics that are rarely used systemically, reducing the risk of sensitization.

INDICATIONS: *Therapeutically,* used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically,* the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

NEOSPORIN® Ointment

(POLYMYXIN B-BACITRACIN-NEOMYCIN)

Each gram contains: Aerosporin® brand Polymyxin B Sul
5,000 units; zinc bacitracin 400 units; neomycin sulfate 5
(equivalent to 3.5 mg. neomycin base); special white petrolat
q.s. In tubes of 1 oz. and ½ oz. and ⅓₂ oz. (approx.) foil pack

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Zip code 48823

Lawyer enumerates areas of neglect in malpractice issue

To the editor:

I do not know if letters to the editor are a general feature of *Michigan Medicine* but I enclose the following thoughts for what they are worth and to be handled as you deem appropriate.

(Ed. note. We are happy to receive all communications, readers' opinions and reactions to articles in Michigan Medicine, *and print those we feel represent valid expressions of readers' viewpoints.)*

The medical malpractice problem was once again highlighted under "Viewpoints" in the *Michigan Medicine* issue of January, 1973. With no disrespect to the doctor or attorney expressing his individual viewpoint, this type of article merely repetitiously reflects the prevailing divergence of opinions and all too often floundering attempts of isolated individuals to seek quick and ready solutions.

Clearly, Michigan physicians are not alone in their concern regarding the magnitude and possible solutions to the problem. As noted in the January 8 issue of *Medical Economics,* the United States Commission on Malpractice after meeting for one and a half years and after going through nearly two million dollars has finally brought forth "its long awaited recommendations." It would not be a bit surprising now that the report is finished and filed, that it will mean the end of the committee with its recommendations probably ending up in file 13.

It would appear to me, as an attorney specializing in professional negligence, that there are two areas of neglect that are so notorious in their contribution to the current dilemma that it would be remiss not to mention them. We must and can work together to remedy them. They are as follows:

1. *Inter-Professional Communication.* The time has come for the lawyers and doctors of Michigan to talk to each other. I noted with dismay in the same January issue of *Michigan Medicine* the report from the Committee entitled "Liaison with State Bar of Michigan." The report was as follows: "This Committee did not meet because no matters were referred." Some inter-professional communication!

I am sending copies of this letter to the respective presidents of the State Bar of Michigan and of the Michigan State Medical Society, and I am publically asking that either existing committees or newly-appointed committees from the two organizations sit down together and at least discuss the situation.

2. *Lawyers Should be Allowed to Act as Specialists.* If a joint committee does come into existence, and I certainly hope that such will occur, I will strongly recommend to the committee and the Bar Association that the time has arrived to set up guidelines for attorneys handling medical malpractice cases. It is a specialized activity and it should be handled by attorneys who have some form of expertise in the field. The guidelines should cover the following areas: investigation, preparation and presentation of the medical malpractice cases. In the *Michigan Medicine* article, Attorney Cline's stated fear that he can "visualize the trend continuing and that there will be more and more medical malpractice cases started simply because the average practicing attorney in the State of Michigan cannot distinguish between malpractice and bad results" can be avoided and should be.

Let's work together.

Sincerely,
L. S. Charfoos
Charfoos and Charfoos law offices
Detroit

Correction in MM article

To the editor:

Thank you very much for the complimentary copies of the February issue of *Michigan Medicine* with our article on our infant transport service. It was very thoughtful of you to include copies for the persons who helped us in the effort. We were very pleased with the appearance of the article. A minor oversight occurred in table 3 where it should have read in the left column: "<1000 g, > 2500 g, and $<$ 24 hours, and $>$ 7 days."

I wish to thank you especially for including the update at the end of the article.

Thank you very much again for your cooperation.

Sincerely yours,
Dietrich W. Roloff, M.D.
Instructor, Department of Pediatrics
University Hospital
Ann Arbor

Let others take responsibility for PSROs

To the editor:

I have read and reread the special bulletin from Dr. Leitch concerning the P.S.R.O. plans. The position of the study committee seems more frightening than endorsable.

Several years ago our long-time delegate and political activist George Kelleher put together the

South Central Michigan Health Planning Council. It was the result of his personal labor and had, he assured us, so many built-in safeguards it was not only capture-proof but pollution-proof. Furthermore, he argued, *if we didn't put together this package we could be assured that someone else* (presumably the bad guys in Washington) *would be happy to do it for us.*

The Council has been ineffectual and unreliable. It has required subsidization by the local hospitals and The County Medical Society and has certainly not served any of these institutions. It has furthermore been polluted and, alas, easily captured. It would still be struggling at the charter committee level if the doctors had not built and endorsed it.

The *New York Times'* Tom Wicker discussed the parallel plight of the news media who are asked to initiate self-censorship in the form of a voluntary press council which will determine the propriety of each original story "in order to keep the press *'free'* by making it more *'responsible'* or" (face the censor's scissors and stamps). *If we don't do it . . . . !*

I understand PL 92-603 is law and that P.S.R.O.'s will follow its passage. The ambiguities in this bill have prompted the editors of *Medical Economics* to ask "Will P.S.R.O. Equal Snafu?" in the issue of February 5th. They fear "stifling regulation in areas where physician judgement is important" and "evasive compliance with negative impact" as a consequence.

I have not read the law, but "evasive compliance" in these areas I understand. I suspect MSMS will be seriously embarrassed when, after endorsing and organizing the program, it crashes at the hand of the medical saboteur and is then taken over by others and "run properly." Let us consider allowing those (who would be happy to put this package together if we don't) to not only attempt it but also be responsible for the results.

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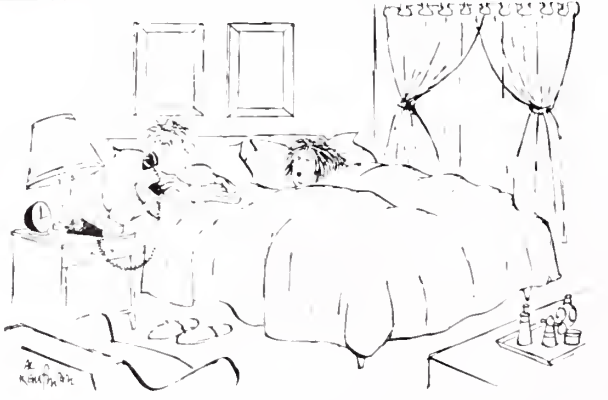
President, Battle Creek



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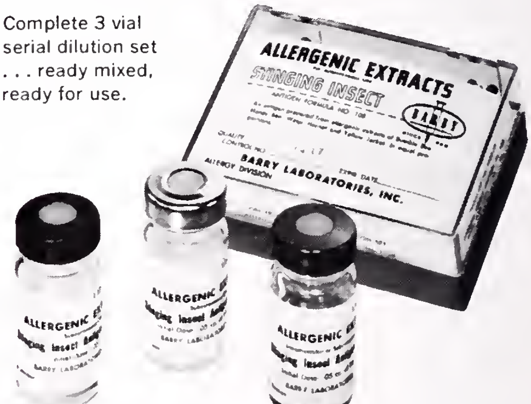

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In memoriam

Erwin Walter Blatter, MD
Port Huron

Erwin Walter Blatter, MD, Port Huron, former medical director of the U.S. Public Health Service for the U.S., Europe and Hawaii, died Jan. 28 at the age of 73.

Doctor Blatter retired in 1962 with the rank of captain, ending a 38-year career with the Public Health Service. He then moved to Port Huron.

Doctor Blatter was graduated from the University of Washington Medical School and practiced privately in Royal Oak for three years. He was a member and secretary of the St. Clair County Medical Society, and was a member of the American College of Hospital Administrators.

Cecil D. Conrad, MD
Birmingham

Birmingham obstetrician and gynecologist Cecil D. Conrad, MD, died Feb. 8 at the age of 61.

A graduate of Wayne State University School of Medicine, Doctor Conrad served with the Air Force during World War II.

Samuel Fried, MD
Southfield

Southfield family physician Samuel Fried, MD, died Jan. 18 at the age of 63.

A graduate of Wayne State University School of Medicine, he was a member of the American Association of Family Physicians, and the Zionist Organization of America. He was on the staff of Brent General Hospital, but had retired in 1972. Doctor Fried previously practiced for 10 years in Saginaw.

Guy D. Houghton, MD
Caledonia

Guy D. Houghton, MD, Caledonia physician for over 65 years, died Jan. 16 at the age of 94. He began practice in Caledonia in 1905 after graduation from the Detroit College of Medicine.

Doctor Houghton had been on the staffs of Butterworth and St. Mary's hospitals in Grand Rapids and served as Caledonia health officer for many years. He was honored by Wayne State University and his community in 1955 for 50 years of practice.

Doctor Houghton had served as Caledonia Village Council chief, president of the bank, member of the school board and draft board.

Douglas E. Maples, MD
Muskegon

A Muskegon anesthesiologist, Douglas E. Maples, MD, died Feb. 25 at the age of 63. Doctor Maples was on the staffs of Hackley and Mercy Hospitals in Muskegon and was a consultant to North Ottawa Community Hospital.

A native of Detroit, Doctor Maples was graduated from Wayne State University Medical School. He moved to the Muskegon area in 1951. Doctor Maples had been a general practitioner for 25 years before becoming an anesthesiologist in 1962.

Doctor Maples was a member of the American and Michigan societies of anesthesiology. He also served as team physician for the North Muskegon schools from 1952 to 1962.

J. Paul Klein, MD
Fremont

Fremont physician since 1946, J. Paul Klein, MD, died Feb. 16 at the age of 60.

Doctor Klein had served since 1947 as an MSMS delegate from Newaygo County, where he also was president and secretary of the medical society.

Doctor Klein retired from active practice in 1970. He had served as chief of staff at Gerber Memorial Hospital, Fremont, and physician for the county selective service board.

He was a graduate of Rush Medical College and began his medical practice in Reed City. He was a charter member of the American Academy of General Practice.

P.C. Robertson, MD
Ionia

The retired medical superintendent of Ionia State Hospital, Perry C. Robertson, MD, died Feb. 6 at the age of 86. Doctor Robertson was a graduate of the University of Michigan Medical School, and the University of Kentucky, where he did further study to become a psychiatrist.

Doctor Robertson served as superintendent of Newberry State Hospital from 1924-1926, and as Ionia Hospital superintendent from 1926-1957 and 1959-1961. He also was active with the local crippled children's society and the Head Start program.

He was past president of the Ionia-Montcalm Medical Society and belonged to the Michigan Society of Neurology and Psychiatry and the American Psychiatric Association.

Herman D. Scarney, MD
Detroit

Herman David Scarney, MD, Detroit ophthalmologist, died Feb. 23 at the age of 72.

Doctor Scarney was former chief of staff and chairman of the Department of Ophthalmology at William Beaumont Hospital, Royal Oak, and also served on the staffs of Harper and Detroit General hospitals. In addition, he was affiliated with the Kresge Eye Institute.

Doctor Scarney was a diplomate of the American Board of Ophthalmology, life fellow of the American Academy of Ophthalmology and Otolaryngology, fellow of the American College of Surgeons and a member of the Association for Research in Ophthalmology.

Richard J. Snyder, MD
Beverly Hills

Detroit-area pediatrician Richard J. Snyder, MD, died March 1 at the age of 47.

Doctor Snyder, a native of Detroit, was graduated from Wayne State University School of Medicine. He was on the staffs of Harper, St. Mary's and Children's hospitals in Detroit. He was certified by the American Board of Pediatrics and belonged to the Detroit Pediatric Society.

Richard A. Stiefel, MD
Battle Creek

Richard A. Stiefel, MD, Battle Creek general surgeon for 40 years, died Jan. 21 at the age of 72. He was a native of Mt. Pleasant, Iowa.

Doctor Stiefel was a graduate of Johns Hopkins School of Medicine, where he gained membership in Phi Beta Kappa honorary. Previously, he had taught at Berea College, Kentucky.

Doctor Stiefel served as surgical consultant to the former Percy Jones Hospital, the Veterans Administration Hospital and American Legion Hospital. During World War II he taught at eight military hospitals in Germany at the request of the U.S. Surgeon General.

Doctor Stiefel was a former president of the Calhoun County Medical Society and was the first president and a life member of the Calhoun County Cancer Society. He was a fellow of the American College of Surgeons and a diplomate of the American Board of Surgeons.

Doctor Stiefel also had served as chief of staff and chief of surgery at Leila Y. Post Montgomery Hospital in Battle Creek.

Garnet G. Stonehouse, MD
Lowell

Garnet George Stonehouse, MD, Lowell radiologist, died Jan. 19 at the age of 76.

He was a graduate of Queens University, Ontario, and was affiliated with St. Mary's Hospital, Grand Rapids. He was a member of the Radiology Society of North America and the American College of Radiology.

Theodore P. VanderZalm, MD
Lansing

Theodore Peter VanderZalm, MD, retired Lansing generalist, died Feb. 3 at the age of 81. Doctor VanderZalm had been affiliated with St. Lawrence, Ingham Medical and Edward W. Sparrow Hospitals in Lansing.

A graduate of the Wayne State University School of Medicine, Doctor VanderZalm practiced in Lansing from 1919 to 1945, when he became head of an Australian hospital while serving with the U.S. Army. He returned to Lansing in 1950.

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William F. Weinkauf, MD
Corunna

A Shiawassee County family physician for more than 50 years, William F. Weinkauf died Feb. 21 at the age of 77. In 1971, his community proclaimed "Doctor Weinkauf Day," and he was honored with a reception attended by 500 guests.

A graduate of University of Maryland Medical School, Doctor Weinkauf was twice chief of staff at Owosso Memorial Hospital, which he helped develop. Doctor Weinkauf also served as physician to area athletic teams and provided medical aid at local jails.

Doctor Weinkauf was a generalist and surgeon and served three times as president of the Shiawassee County Medical Society.

George Wickstrom, MD
Owosso

George B. Wickstrom, MD, retired Shiawassee County public health director, died Feb. 28 at the age of 70.

Doctor Wickstrom had practiced privately in Dowagiac and Munising, where he served for 24 years. He moved to the Shiawassee County area in 1960 to engage in public health work for both Shiawassee and Livingston counties.

Doctor Wickstrom was a graduate of both the U-M medical and public health schools. He was past president of the Marquette-Alger Counties Medical Society and served as a member of the Genesee, Shiawassee and Livingston county health planning councils.

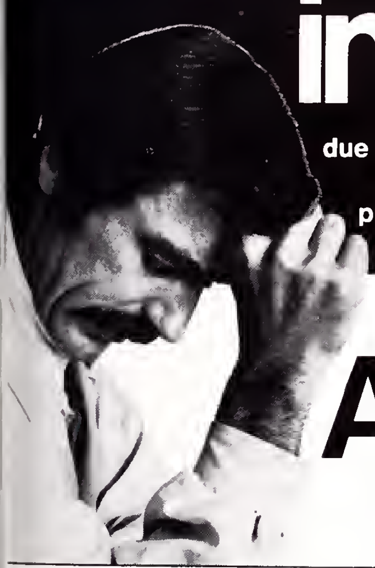
William R. Young, MD
Lawton

Lawton area physician since 1913, William Rae Young, MD, died Feb. 2 at the age of 83.

Doctor Young had served 60 years as family physician and later the first anesthetist specialist in the area. He was affiliated with Lakeview Community Hospital, and Borgess and Bronson hospitals in Kalamazoo.

A past president of both the Van Buren and Kalamazoo county medical societies, Doctor Young also served as delegate to MSMS for many years. In 1963, Doctor Young was honored by his community for his 50 years of service.

He was a member of the Michigan State Anesthesiology Society and the American Society of Anesthesiology.



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Physicians should know new workmens' comp regulations

Changes in the workmen's compensation laws now make it easier for some afflicted and injured persons to work and relieve the employer of some of the liability.

They also are important for physicians to know, particularly those who do pre-employment physicals, says Stuart L. Cohn, MD, Alpena, chairman of the MSMS Rehabilitation Committee.

"Under this new law the worker with such conditions can be certified as a 'vocationally handicapped worker,' and the employer only has limited liability if the condition recurs," explains Doctor Cohn.

Physicians who give pre-employment physicals and others who see workers unemployed due to physical disability should contact their district office of the Vocational Rehabilitation Service to ascertain the details of the new legislation, Doctor Cohn urges.

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Planning priorities committee reports

Proposals Focus on MSMS Purposes, Objectives

Council, House sent recommendations of Planning-Priorities Committee

By Herbert A. Auer, Manager
MSMS Communications Department

The MSMS Planning and Priorities Committee, appointed in January 1972, has sent its first recommendations to the MSMS Council.

The progress report, with recommendations to update the MSMS purposes and to advocate both short-range and intermediate objectives, was submitted by the committee chairman, Stuart M. Gould, MD, a member of the MSMS House of Delegates from the Washtenaw County Medical Society.

Because the recommendations will require final consideration by the MSMS House of Delegates, MSMS Council Chairman Robert Leitch, MD, relayed copies of the progress report to the members of the House. This practice has been followed in the past for the reports of the RVS Committee and others.

"The report reviews briefly our committee work to date and offers a series of recommendations dealing with the MSMS purposes and objectives," explains Doctor Gould.

"The committee will continue its work and this coming fall will present more recommendations about possible changes in MSMS structure, priorities, committees, member services, and MSMS responsibilities to the public," Doctor Gould added.

Committee was named 16 months ago

The Planning and Priorities Committee was appointed in January, 1972 and includes representatives from the MSMS House, MSMS Council, both large and small component societies, the Council of Medical Specialties, medical students, women, blacks, and other segments and interests. The Council charged the committee to study MSMS priorities and to consider possible duplication of committee work.

"The Council was aware that functions and projects were continually being added but there was little, if any, review of or elimination of the existing activities. The Council wanted some planning and wanted to determine priorities for MSMS projects and activities," explains Doctor Gould. Doctor Gould outlined much of this background in this report to the 1972 fall meeting of the MSMS House.

Committee is evaluating Grant study

The House of Delegates the previous year had authorized an outside consultant group to conduct a survey of attitudes held by MSMS members.

The report of that opinion survey (known as the Phase II Report) from the Alexander Grant Company was sent in the spring of 1972 to the members of the MSMS House. One of the reference committees at the House meeting last spring studied the report, heard various comments, and decided against a proposed special House committee to study the report. The reference committee, in its report, expressed the view that the Planning and Priorities Committee was broadly based and should study the findings and recommendations in the opinion survey.

The Alexander Grant report discussed member services so a subcommittee of the Planning and Priorities Committee spent two meetings examining the attitudes expressed and in developing a report back to the parent committee.

"The full committee adopted recommendations

PRIORITY
ONSTITUTION
E PURPOSES

of a preliminary nature about member services. These will be reviewed again and presented formally to the 1973 fall session of the House and to the MSMS Council," Doctor Gould reports.

"Understandably all the ideas about member services have to be measured or balanced against the human and financial resources of MSMS," Doctor Gould observes.

Committee is weighing changes in structure

Based on attitudes expressed by the members, the Alexander Grant study recommended certain changes in the structure of MSMS and the component societies. "It was very difficult to get a handle on this part of the job so we decided we could react better to the Alexander Grant suggested changes in structure if we had some other models to consider," Doctor Gould declares. The committee has developed now, in considerable detail, four different models or exercises. Committee members report that they are impressed with the fact that there are an almost infinite number of combinations of organizational ideas.

The current report to the Council and the House states that, "The committee members believe that action this spring on recommendations about MSMS purposes and objectives will permit the committee to review and finalize its thoughts about possible improvements in structure."

"Committee members at almost every meeting have remarked that changes should not be suggested merely for the sake of change," Doctor Gould stresses.

Copies of the several organizational exercises have been shared by the committee with the MSMS Council.

Several terms have been defined, clarified

Throughout the early meetings of the committee there seemed to be no agreement about certain words, such as "purposes," "objectives," "goals," "activities," "projects." It was possible to interchange them from time to time, but that practice presented problems too.

To provide guidance, the committee agreed on the following definitions:

> "Purpose"—the reason why MSMS exists.
>
> "Objectives"—a specific goal that can be reached and success can be measured.
>
> "Activity"—a project or effort to reach one of the objectives.

Using these definitions, the committee reviewed the "Council Objectives" that were developed by MSMS Council members in December. It was decided that some of those projects really were activities rather than objectives. The committee members added other objectives and changed the wording of some of those on the Council list.

Committee members agreed that any list of MSMS objectives should spell out MSMS efforts (1) to serve MSMS members, (2) to serve the patients, and (3) to serve the public.

The committee members then tried to sort the objectives into a list of current objectives and a list of those that are viewed as areas that MSMS should move into.

Proposed current objectives for MSMS

The committee is recommending to the Council and the House the following ongoing current objectives that should be supported:

1. Seek solutions to Medicaid problems.

2. Monitor and coordinate development of PSROs in Michigan.

3. Create medical care guidelines for adoption by regional PSROs.

4. Develop and support MSMS policies re current legislation.

5. Introduce legislative measures to alleviate professional liability insurance problems.

6. Initiate a move effective informal liaison with Michigan Medical Service.

7. Continue efforts by MSMS officers, Councilors and staff members to visit each component medical society.

8. Continue new efforts to improve and increase MSMS working relationships with the medical specialty societies and the Council of Medical Specialties.

9. Increase assistance to components in membership retention and recruitment.

Proposed intermediate objectives for MSMS

The committee feels that MSMS should begin to work in some areas and has suggested 12 intermediate objectives. They are:

1. Develop continuing medical education certification plan for Michigan.

2. Begin efforts to involve MSMS in MD placement activities.

3. Carry forward the five present MSMS public relations projects, which are VD education, Education about the Medical Aspects of Pollution, Chiropractic Education, Work to Make Medical Assistants More Effective Communicators, and Help People Find a Doctor, and to especially concentrate on projects to educate both the physician and the public about chiropractice.

4. Conduct and evaluate MSMS sponsored prac-

tice management seminar on a pilot basis.

5. Conduct several opinion surveys of MSMS membership on important issues.

6. Study trends of utilization of emergency rooms and recommend appropriate MSMS involvement.

7. To continue to improve techniques and methods of communicating with the members and the public; and to encourage communication from the members to MSMS.

8. Coordinate and enlarge the negotiating activities in the broadest sense.

9. Develop program of member assistance.

10. Encourage and assist component medical societies so they can take active roles in community health related programs such as area-wide planning.

11. Explore and determine the proper MSMS role in matters of state and federal funding of medical and health services.

12. Develop concepts and models of ambulatory care systems so physicians can provide leadership in this matter.

Need seen to establish priorities

Neither the list of current objectives or the list of intermediate objectives is in any order of priority. Doctor Gould has told the Council that "after the House has acted to approval or modify the two lists, then the Planning and Priorities Committee will advise and counsel the Council in detetermining priorities.

In the new report of the committee to the Council and the House, the chairman points out that "action on these objectives should not be limiting because the Council will have to adopt immediate and short-range objectives from time to time as new opportunities or situations are identified. The Council will have to act within the policy frameworks adopted by the House."

"The Committee on Planning and Priorities plans to review the current objectives and intermediate objectives annually in order to keep the organization relevant and vital," stresses Chairman Gould.

MSMS committees under review

The committee during the past 16 months have reviewed the purposes and work of the present MSMS committees and considered the possibilities of eliminating some and adding others.

Recommendations about MSMS committees will be made next fall.

Committee Would Update, Streamline MSMS Constitution re Purposes

The MSMS Committee on Planning and Priorities discussed the MSMS purposes as stated in the Constitution and Bylaws many times, and then spent considerable time at both the Feb. 7, 1973 and March 21, 1973 meetings on the subject.

There was general agreement that the present purposes, which were revised and updated by the House of Delegates in 1971, are quite accurate today. Some minor changes in wording were recommended. The Committee recommends that several new statements be added either to put in writing some purposes that MSMS indeed does seek to accomplish or to add some new purpose that would be appropriate because of changing conditions.

The Committee agrees that the first purpose in the present constitution is the general, over-all foundation for MSMS, and should be given paramount focus and attention. The other suggested purposes support and compliment the first, central purpose.

The first purpose in the present Constitution, according to Chairman Stuart M. Gould, seems to say it all just right. Following is the statement:

> **"To bring into one viable, effective organization the ethical physicians, licensed to practice in Michigan, in order that their contribution to human welfare will be enhanced."**

In the list of purposes being proposed by the committee, all the others fall under than one in an outline style "because they seem to support and compliment it," says Doctor Gould.

The committee is presenting to the Council and House the following list of purposes. The MSMS constitution contains the present list which can be reviewed by members interested in comparing the two sets in detail. Following are the proposed purposes, with some comments to show generally the relationship to some present purpose. The first, major purpose is repeated with the others following as subpoints.

Proposed purposes of MSMS

"To bring into one viable, effective organization the ethical physicians, licensed to practice in

Michigan, in order that their contributions to human welfare will be enhanced."

"MSMS will accomplish this overall purpose by striving to fulfill the following complementary purposes:

"A. To constitute, support and advise the American Medical Association in cooperation with similar societies of other states, in meeting its appropriate responsibilities."

"B. To charter and organize constituent component medical societies." (Note: Present purpose #2 has been divided and modified slightly into A and B.)

"C. To conceive, develop and administer health education programs designed to improve public understanding, awareness and acceptance of good medical standards, practices and concepts, as they relate to personal health, scientific progress and society's advancement." (Note: Same wording as present purpose #3.)

"D. To stimulate advancement of the science and art of medicine and continually to seek to advance the medical, scientific, social, environmental, economic and medical political knowledge of its members in order that the doctor may better serve his patients and the public health generally." (Note: same wording as present purpose #4.)

"E. To aid Michigan physicians individually and collectively in maintaining high levels of ethical conduct and standards of practice to protect and serve the total public." (Note: same wording as present purpose #5.)

"F. To provide medical leadership in meeting the health needs of the people by working with other medical and non-medical groups and individuals." (Note: this is a shortened version of present purpose #6.)

"G. To enhance physician-patient relationships, as basic to the delivery of quality health care." (Note: this is a shortened version of present purpose #7.)

"H. To promote quality medical and health care by development and support of activities appropriate to this goal." (Note: present purpose #8 has been shortened and divided into H and I.)

"I. To advocate fair remuneration for services rendered." (Note: this statement was made in present purpose #8.)

"J. To ensure the adequacy of medical manpower by attracting capable people into the medical and health professions and to work toward the most effective distribution of their services." (Note: the intent of this purpose is in present purpose #9. The proposed wording, the committee feels, is more realistic.)

"K. To encourage medical students and physicians-in-training to participate in organized medicine in order to enable MSMS to be representative of all physicians." (Note: this is a shortened version of present purpose #10.)

"L. To support the efforts of those who would enhance the reputation and services of the medical profession." (Note: this is the same as present purpose #11 but phrased in a positive manner. Purpose #11 now calls for MSMS "to combat . . . those who would denigrate . . . the profession.)

"M. To institute and provide specific services to meet the needs of the members." (This is a new purpose, but has been a goal over the years.)

"N. To foster and support continuing medical education." (This is a new purpose but also has been an ongoing purpose.)

Meet Busy Members Of Planning Committee

In presenting their progress report to the MSMS Council and the spring meeting of the MSMS House of Delegates, the committee members stated: "We want to thank the MSMS officers, councilors, committee chairmen, component society officers, specialty society leaders, MSMS staff members and all others for their assistance and advice in the work done to date. The entire project has been an interesting challenge and the committee is eager to continue its deliberations."

Members of the MSMS Committee on Planning and Priorities are:

Stuart M. Gould, MD, chairman, Ann Arbor
James B. Blodgett, MD, Detroit
M. C. Burton, MD, Grand Rapids
Dean P. Carron, MD, Ann Arbor
Ned I. Chalat, MD, Detroit
John J. Coury, MD, Port Huron
Richard R. Galpin, MD, Birmingham
D. Bonta Hiscoe, MD, Lansing
Francis A. Martin, MD, Pontiac
Brooker L. Masters, MD, Freemont
Richard J. McMurray, MD, Flint
Marjorie Peebles Meyers, MD, Detroit
Frank L. Pettinga, MD, Muskegon
Maurice S. Reizen, MD, Lansing
Randall S. Riggs, WSU medical student
Frederick C. Sabin, MD, Marquette
Homer M. Smathers, MD, Detroit
Frank B. Walker, II, MD, Detroit
John R. Wilson, MD, Grand Rapids
John Ylvisaker, MD, Royal Oak

The committee met once in Detroit with the members of a Wayne County Medical Society companion committee as guests. Two representatives of the Wayne committee also participated in two other meetings of the MSMS committee.

President's page

John J. Coury, MD
MSMS President

This is a personal appeal to each MSMS member to decide today to correct one of the serious problems we face.

I'm talking about the way the telephone is answered in the office of a doctor I know - or two or three doctors I know in different towns.

In no way am I putting all the blame on any busy office girl but I am addressing this message to each doctor who really is responsible for the way the telephone is answered in his office.

Everyday there are thousands of Michigan people who call physicians in Michigan. Many are asking their family doctor for an appointment. A few are calling to cancel an appointment because they feel better.

I'm deeply concerned about the many, many, many other people who call to try to find a doctor who will see them or who will accept them as a regular new patient.

How does your own office girl handle the mother who calls appealing for an appointment for a sick child?

Does the office girl really know whether you are able perhaps to take on several more patients this week?

If you cannot accept another patient today, what have you told the office girl to say? Does she somehow show your compassion for the caller?

Personally, I believe that public confidence and patient respect is related to the way the telephone is answered, or the way we demonstrate our genuine concern for each and every patient we see.

Ask yourself:

1. Could I improve my efficiency and see several new patients?
2. Could I train my office girls to show more concern for those patients that just cannot be seen?
3. Could each of us join with our colleagues to determine some better ways through the component medical societies to help people get a doctor, or to help them get good care by a medical doctor.

The MSMS Committee on Public Relations is moving along 5 major projects and perhaps the most important is "How can MSMS help people get a doctor?"

The Committee and the MSMS Council has sent copies of working papers for the 5 projects to each component society urging them to study the situation and then decide to take some positive action. The MSMS Department of Communications offered its advice and assistance. A few components have started some pilot projects.

MSMS is busy also trying to improve the telephone problems I pointed out here. MSMS just recently conducted an effective pilot "Workshop on Better Telephone Techniques" for 30 medical assistants. If you want to help arrange such a workshop in your community, just phone MSMS.

* * *

What can you do to help people get medical care?

1. Improve procedures for public to follow in trying to get a doctor
2. Improve bridge from emergency department to private physician care
3. Establish central office to help new residents find a family doctor
4. Improve relationships between medical students and your community
5. Encourage your hospital to participate in the SAMA-MECO project
6. Encourage more medical students to stay in Michigan for their internships
7. Develop projects to encourage more residents and interns to stay in Michigan
8. Urge non-practicing MD wives to practice at least part time.

* * *

There are some medical public relations-socio-economic-political problems that are very complex but here is one that every aware, concerned doctor can improve.

How about it, doctor?

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MSMS leaders speak out:

Here's what's in it for you as an AMA member

By Brooker L. Masters, MD
MSMS vice president

You have strong representation in Washington looking after your interests at the federal lawmaking level . . .

If the American physician's views are to be heard nationally, your rights protected, your interests fostered, you must have a single, strong voice speaking for you. The AMA is that spokesman, serving as the intermediary between the doctor and the government.

The basic AMA position is that the private sector can best bring about the improvement of health care services. Where the private sector's resources are insufficient, government funds must be secured. While government support is necessary in some areas, the AMA does not believe government should be permitted to dictate the terms of medical practice and education. This would not be in the interest of either the profession or the nation.

During the last year alone, the AMA coped effectively with national health insurance legislation, Health Maintenance Organizations, Professional Standards Review Organizations, chiropractic in Medicare, catastrophic expense coverage, medical manpower proposals, cancer and heart research support and many other controversial issues.

In 1973, AMA will go to the mat on such issues as unannouced federal inspection of your records; federal chiropractic inclusion; federal honor oaths; federally run peer review, federal compulsory generic prescribing; federal fee schedules; federal HMO's . . . and an $84 billion national health insurance program that will require re-licensure of all doctors in the United States.

* * *

In addition to protecting your interests in Washington last year, the AMA sponsored various programs for the benefit of doctors. Among them . . .

The "Quality of Life": The AMA's Congress on the Quality of Life conducted in Chicago was structured to provide national impetus to a better quality — and therefore improved — health at the beginning of life.

Scientific Assembly and Postgraduate Education: For the first time, postgraduate courses were offered at an annual convention. All seven courses were sold out a month before the meeting. This is one of many changes in the Scientific Assembly that the Board of Trustees and Council on Scientific Assembly are considering as efforts are made to improve programs and increase attendance.

Prescription Drugs: The first edition of AMA-Drug Evaluations was distributed to 230,000 physicians, the most widely circulated single edition of a medical text ever published. A revised, updated 2nd edition will be published in 1973.

Medical Education: This AMA Council, its committees, and staff are an integral part of America's medical educational effort. Without the daily application of these enormous resources, the production of new physicians and their subsequent graduate and continuing education would experience a sharp setback.

Education of Allied Health Professions and Services: Nineteen medical specialty and allied health associations cooperated with AMA in setting standards and approving educational programs for allied health occupations.

This list of AMA benefits also should include group insurance programs, the extensive AMA medical library, socio-economic surveys, national placement service, many publications.

'72 House action counsels members

By Vernon V. Bass MD, Speaker
MSMS House of Delegates

Because of the importance of Resolution 27 adopted by the last MSMS House of Delegates, I would like to review the reasons why each of you should consider again the House action.

MSMS and its members have a rich history of working as an organization to counsel physicians in all ways possible to provide the very best of medical care.

That background alone could be the foundation for Resolution 27, which instructed MSMS "to inform all members of the legal and ethical implications of assigning patients to emergency or

(Continued on page 337)

ABBOTT

Placidyl®
ETHCHLORVYNOL)
Brief Summary

ndications—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

Contraindications—Drug hypersensitivity and porphyria.

Warnings—Not recommended during the first and second trimester of pregnancy. Caution patients of possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness afer taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorynol therapy, during therapy, or after stopping herapy. This drug is not recommended for use in hildren. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMLAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who re likely to increase dosages of the drug on their wn initiative should be observed for evidence of igns or symptoms which may indicate possible arly withdrawal or abstinence symptoms. Signs nd symptoms associated with withdrawal and abtinence include unusual anxiety, tremor, ataxia, lurring of speech, memory loss, perceptual disortions, irritability, agitation and delirium. Other ess well defined signs and symptoms, not necesarily due to withdrawal and abstinence, may inlude anorexia, nausea or vomiting, weakness, izziness, sweating, muscle twitching and weight oss. Abrupt discontinuance of Placidyl following rolonged overdosage may result in convulsions nd delirium.

recautions—Toxic amblyopia has been reported ith long-term continuous use of ethchlorvynol. ermanent visual defects have been observed, alhough amblyopia has improved after discontinuaon of the drug. Drug dosage should be limited or elderly and debilitated patients to the smallest effective amount. If pain is present, this drug hould only be given if insomnia persists after ain is controlled with analgesics. Caution is adsed in prescribing the drug for patients who are eing treated with either MAO inhibitors or antiepressants. Transient delirium has been reported ith the combination of Placidyl and amitryptyline. rug dosage should be reduced if prescribed for atients receiving MAO inhibitors or antidepresants. Caution should be exercised in patients ith impaired hepatic or renal function. Patients ho respond unpredictably to barbiturates or alcool, or who exhibit excitement and release of inhition in association with such agents, may also eact in this way to Placidyl. Rarely, patients may xhibit symptoms suggestive of an unusual suseptibility to the drug; such as prolonged hypnosis, rofound muscular weakness, excitement, hysteria, syncope without marked hypotension. Transient ddiness or ataxia may occur.

dverse Reactions—Hypotension, nausea or vomng, gastric upset, aftertaste, blurring of vision, zziness, facial numbness, and allergic reaction pified by urticaria have been reported following acidyl administration. Mild "hangover" and sympms of mild excitation have occurred in some atients. There have been rare reports of cholestatic undice occurring in patients taking ethchlorvynol. few cases of thrombocytopenia have been reorted in patients receiving ethchlorvynol. 305432

Give us her nights.

Prescribe Placidyl. Chances are, we'll give her a good night's sleep.

Insomnia is often suffered by the elderly. Anxiety and agitation might be the cause. Or the effect. In time that can be determined. But tonight one fact is painfully clear: she needs sleep.

When sleep is synonymous with therapy, remember . . . Placidyl is synonymous with sleep. It has been for over 17 years.

If time is the criterion to inspire your confidence . . . you can rest assured with Placidyl.

Prescribed by physicians for over 17 years.

Placidyl® Ⓒ IV

(ETHCHLORVYNOL CAPSULES, 500 or 750 mg.)

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The Publication Committee of the MSMS Council is the editorial board of *Michigan Medicine* and advises the Council and the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

Small doses

John H. Bihl, MD, Livonia,
is new emergency physician to the Livonia police department, on call 24 hours a day. He also is medical director of the Family Care Medical Group, and medical director of the University Convalescent Home in Livonia.

Stefan S. Fajans, MD, Ann Arbor,
is the subject of a feature article entitled "Tracking the hidden threat of diabetes," which appeared in the March 19 issue of *Modern Medicine.* Doctor Fajans is professor of internal medicine in the division of endocrinology and metabolism and the metabolic research unit of the U-M Medical Center.

Thomas Green, MD, Detroit,
is a new member of the Task Force on Developing Regional Guidelines of the AMA Advisory Committee on PSRO.

Thomas C. Hall, MD, Traverse City,
won both the slalom and giant slalom skiing competitions to earn the combined trophy in the second annual United States National Ski Championships for Physicians and Dentists in Snowmass, Colo., Feb. 27 and 28.

Ray E. Helfer, MD, and Andrew D. Hunt, Jr., MD, East Lansing,
have been named Gerber Scholars in Human Development. Doctor Hunt is dean of the MSU College of Human Medicine while Doctor Helfer is associate professor of human development. Doctor Hunt will study medical education at European medical schools during a three-month sabbatical leave, while Doctor Helfer will review protective services programs established to help abused and neglected children and their families in major cities of Michigan and other states.

Andrew D. Hunt, Jr., MD, East Lansing,
is new vice chairman of the Regional Advisory Group for the Michigan Association for Regional Medical Programs. Doctor Hunt is the dean of the College of Human Medicine at MSU. He is a past president of the MARMP board.

(Continued on page 340)

Sally's back in sew biz! After an arthritic flare-up.

t Note: This drug is not a simple analgesic. Do
inister casually. Carefully evaluate patients be-
ting treatment and keep them under close su-
. Obtain a detailed history, and complete
and laboratory examination (complete hemo-
inalysis, etc.) before prescribing and at fre-
ervals thereafter. Carefully select patients,
those responsive to routine measures, contra-
 patients or those who cannot be observed fre-
Warn patients not to exceed recommended
Short-term relief of severe symptoms with the
possible dosage is the goal of therapy. Dosage
e taken with meals or a full glass of milk. Sub-
ka capsules for tablets if dyspeptic symptoms
atients should discontinue the drug and report
tely any sign of: fever, sore throat, oral lesions
ms of blood dyscrasia); dyspepsia, epigastric
nptoms of anemia, black or tarry stools or other
 of intestinal ulceration or hemorrhage, skin re-
significant weight gain or edema. A one-week
od is adequate. Discontinue in the absence of a
 response. Restrict treatment periods to one
patients over sixty.
ns: Acute gouty arthritis, rheumatoid arthritis,
oid spondylitis.
dications: Children 14 years or less; senile pa-
story or symptoms of G.I. inflammation or ul-
including severe, recurrent or persistent dys-
istory or presence of drug allergy; blood
as; renal, hepatic or cardiac dysfunction; hy-
on; thyroid disease; systemic edema;
s and salivary gland enlargement due to the
lymyalgia rheumatica and temporal arteritis;
eceiving other potent chemotherapeutic
r long-term anticoagulant therapy.
s: Age, weight, dosage, duration of therapy, ex-
f concomitant diseases, and concurrent potent
erapy affect incidence of toxic reactions. Care-
uct and observe the individual patient, espe-
aging (forty years and over) who have
 susceptibility to the toxicity of the drug. Use
fective dosage. Weigh initially unpredictable
against potential risk of severe, even fatal, re-
The disease condition itself is unaltered by the
e with caution in first trimester of pregnancy
rsing mothers. Drug may appear in cord blood
st milk. Serious, even fatal, blood dyscrasias,

Butazolidin® alka Geigy

Each capsule contains:
100 mg phenylbutazone USP
100 mg dried aluminum hydroxide gel USP
150 mg magnesium trisilicate USP

If it doesn't work in a week, forget it.

including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight, complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement. (B)98-146-070-G

Serious side effects do occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings, contraindications and adverse reactions.

For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

BU 8615-9

What should a medication for sleep be expected to provide?

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psycholc dependence have not been reportec recommended doses, use caution in ministering to addiction-prone indiv or those who might increase dosage

Precautions: In elderly and debilitat initial dosage should be limited to 15 to preclude oversedation, dizziness or ataxia. If combined with other dru having hypnotic or CNS-depressant effects, consider potential additive e Employ usual precautions in patien who are severely depressed, or with

Sleep for 7 to 8 hours without need to repeat dosage during the night

No sleep medication has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia patients given one 30-mg capsule of Dalmane at bedtime, on average: fell asleep within 17 minutes, had fewer nighttime awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to repeat dosage during the night.

Sleep with consistency

Dalmane (flurazepam HCl) has been shown to be consistently effective even during consecutive nights of administration. Thus there is little likelihood for the need to increase dosage to maintain therapeutic effect.

Dalmane is in a class by itself. Not a narcotic, barbiturate or methaqualone, Dalmane is the only available benzodiazepine specifically indicated for insomnia.

Sleep with relative safety

Chronic tolerance studies have confirmed the relative safety of Dalmane (flurazepam HCl); no depression of cardiac or respiratory function was noted in patients administered recommended or higher doses for as long as 90 consecutive nights. In most instances when adverse reactions were reported they were mild, infrequent and seldom required discontinuance of therapy. Morning "hang-over" with Dalmane has been relatively infrequent. Dizziness, drowsiness, lightheadedness and the like have been the side effects noted most frequently, particularly in the elderly and debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

When your evaluation of insomnia indicates the need for a sleep medication, consider Dalmane—a single entity agent proved effective and relatively safe for relief of insomnia.

DALMANE®
(flurazepam HCl)
When restful sleep is indicated

One 30-mg capsule *h.s.*—usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.*—initial dosage for elderly or debilitated patients.

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t depression or suicidal tendencies.
dic blood counts and liver and kid-
unction tests are advised during
ated therapy. Observe usual precau-
in presence of impaired renal or
tic function.

rse **Reactions:** Dizziness, drowsi-
lightheadedness, staggering, ataxia
alling have occurred, particularly
erly or debilitated patients. Severe
ion, lethargy, disorientation and
, probably indicative of drug intoler-
or overdosage, have been reported.

Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

Opinion & Dialogue

"Prescription drugs – who should determine the maker?"

Dispenser of Medicine

Clifton J. Latiolais
President
American Pharmaceutical Association

"Too many doctors are indifferent to the economic consequences their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by form AMA Chief Executive F. J. L. Blasingame, M.D.

Doctor, are you indifferent . . . ?

In discussing an anticipated increase in Blue Shield rates, Dr. Blasingame's newsletter had this to say:

"In general, it can be said, MD have given the impression they are not particularly concerned with the increase in cost of health care to th patients . . .

"True, an MD's training is primarily scientific, but in the real wor of practice, all of his scientific decisions have a price tag, or an econon impact. The economics of health ca beckon the practitioner's attention. Concern for economics of medicine

Maker of Medicine

C. Joseph Stetler
President
Pharmaceutical Manufacturers Association

When the pharmacist recommends that a drug product other th the one ordered be dispensed, the prescriber invariably permits the change when he feels the best interests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is nec sary for the prescriber to know that the change is being contemplated, and to be in a position to consent o demur. Without that opportunity, th unilateral decision of the pharmaci made in the absence of clinical kno edge of the patient, could expose h to needless risks, and in addition, jeopardize the relationship betwee the professions of Pharmacy and Medicine. In my view, there is noth in the pro-substitution argument th offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowlec about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degr puts him at a disadvantage. Most often, a practicing physician will ne expert knowledge of no more than

Advertisement

ould be an obligation of medical ctice…

“Medical societies ought to con- ct continuing campaigns to point the substantial savings that could realized thru deductible insurance d protection for catastrophic ill- ss. At the very least, they should, in patients' interest, question the tics of any insurance organization t raises health care costs by forc- policyholders to buy insurance y may not need or want and prob- y won't ever use.

“Too many doctors are indiffer- to the economic consequences of ir decisions. Too many, for ex- ple, habitually hospitalize patients the convenience of the MD. It's nsense to deny such habits exist…

“Doctors, thru their medical so- ties, have unhesitatingly appealed heir patients for support in the nt against government interference h the private practice of medicine. d the public in the past has re- onded. It's time the American Med- l Association and state and local dical societies paid off the debt by cisive action to hold down the cost medical care.”

st of Drugs

Insurance rates and hospital rges are only two factors in health care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists *are concerned*. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. “Drug product selection” simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the “White Paper on the Pharmacist's Role in Product Selection” from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

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30 drugs that he selects to treat the jority of conditions encountered in practice. Moreover, the physi- n's choice of a specific brand is ed on his knowledge of the pa- nt's medical history and current ndition, and his experiences with particular manufacturer's duct.

Some substitution proponents e argued that the dispensing of a scription is a simple two-party nsaction between the pharmacist l the patient, and that a substitut- pharmacist may avoid even a nnical breach of contract by simply ifying the patient that he is making substitution. I would judge that courts would be sympathetic ard a pharmacist who substituted nout physician approval and who lertook a legal defense that seeks nake the patient responsible for pharmacist's actions.

uced Prescription Prices?

Substitution advocates are gesting to the consumer, and par- ilarly the consumer activist, that uced prescription prices could ow legalization of substitution. have seen absolutely no evidence ustify this claim. To the contrary, erience in Alberta, Canada, where stitution is authorized, suggests the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep “slow moving” products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor “corner cutting” pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advocates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, “The Medications Physicians Prescribe: Who Shall Determine the Source?” It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

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#3, codeine phosphate* (32.4 mg.) gr.
#4, codeine phosphate* (64.8 mg.) gr.

Doctor Bass

Doctor Leitch

other broad-scope services during absence from practice."

As is usually the case, the MSMS delegates anticipated possible problems now that more hospitals have around-the-clock emergency departments. Therefore the House action can be interpreted as an alert, as a warning.

The resolution was introduced by MSMS Past President H. H. Hiscock, MD, of Flint. It is so well stated that I feel it proper to reprint the resolution.

"Whereas, the physician-patient relationship implies physician responsibility to provide medical attention to the patient at any time, and
"Whereas, physicians, like other persons, leave their community on occasion for educational, recreational and other purposes, and

"Whereas, some physicians apparently are under the delusion that they can safely assign their patients to hopsital emergency rooms for service during their absence, but in many cases emergency room staff cannot supply the complete medical attention expected in the usual physician-patient relationship, this being particularly true with respect to patients in critical stages, and the physician may thereby fail to fulfill his obligation to provide full-time complete coverage to the patient, and
"Whereas, issues may arise from such situations leading to charges of malpractice, abandonment or negligence, therefore be it
"RESOLVED: That MSMS inform all its members of the legal and ethical implications of assigning patients to emergency or other broad-scope services during absence from practice."

The MSMS Legal Counsel, A. Stewart Kerr, concurs with the resolution and does indeed counsel MSMS members to continue to exercise wise judgement whenever it is necessary to assign patients to other physicians.

Members with specific questions are urged to write to Mr. Kerr in care of the MSMS headquarters.

MSMS needs Blue Shield and vice versa

By Robert M. Leitch, MD
Council Chairman

With the prospect of some type of national health insurance a definite possibility within the next few years, the futures of MSMS and Blue Shield of Michigan become inexorably linked.

If NHI takes the form of government subsidy for catastrophic coverage and care of the medically indigent, private carriers and the medical society will have to cooperate to make it operative. If we should be unfortunate enough to get an all-inclusive "socialized medicine" bill of the Kennedy-Griffiths type, then neither organization will have a viable future.

It therefore becomes incumbent on MSMS and Blue Shield to blend their efforts toward forestalling Kennedy type legislation and making some more palatable type succeed if it becomes law. Ideally, no further government intervention should be our goal.

Historically, MSMS and Blue Shield were for many years intimately associated.

MSMS was instrumental in the development of Blue Shield and for many years, the House of Delegates of MSMS formed the principle portion of the Corporate Body of Blue Shield.

With the advent of the "age of consumerism" and other factors, it was necessary for the "divorce" which occurred several years ago to take place. The two organizations have gone their separate ways since that time with no formal liaison and no satisfactory means of input from one to the other.

The Corporate Body at present is composed of representatives of several organizations, the Michigan Association of Osteopathic Physicians and Surgeons, Michigan Hospital Association, Michigan Pharmaceutical Association, consumer groups and others. These members are "ex officio" from their respective parent organizations and as such are able to provide significant input to Blue Shield, and vice versa.

The MD members of the Corporate Body however, do not represent MSMS. They are merely individual MD's selected by Blue Shield to "fill the chairs" of the required number of MD members.

It would seem that if the relationship between MSMS and Blue Shield is to be meaningful, a point of formal liaison should be established. The MD membership of the Corporate Body appears to be a logical point of liaison and I understand that a resolution is being introduced in the Spring House of Delegates meeting which would have the MD members of the Corporate Body elected or appointed by the House. Such a proposal deserves thoughtful, serious and unemotional study.

MSMS needs Blue Shield and the reverse also is true. In the turbulent days ahead this will be true more than ever before. The future viability of both organizations is at stake.

SYNTHROID
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T_4 IS THE PREDICTABLE HORMONE BECAUSE IT LOVES PROTEIN.

SYNTHROID® (sodium levothyroxine) is pure synthetic T_4, the major circulating thyroid hormone. It is reliable to use because of its affinity for protein-binding sites in the blood. T_3 is more fickle. Sometimes it binds. Sometimes it doesn't. T_4 more *predictably* binds to protein.

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ALL THYROID-FUNCTION TESTS ARE USEFUL IN MONITORING SYNTHROID THERAPY

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Any of the commonly used T_4 thyroid function tests (P.B.I., T_4 By Column, Murphy-Pattee, Free Thyroxine) are useful in monitoring patients on T_4 because they *all* measure T_4. Patients on SYNTHROID are thereby easy to monitor because their results will fall within predictable, elevated test ranges. Of course, clinical assessment is the best criterion of the thyroid status of the drug-treated patient.

TEST	HYPOTHYROID	SYNTHROID THERAPEUTIC NORMAL
P.B.I.	Less than 4 mcg %	6-10 mcg %
T_4 By Column	Less than 3 mcg %	7-9 mcg %
T_3 (Resin)	Less than 25%	27-35%
T_3 (Red Cell)	Less than 11%	11.5-18%
Free Thyroxine	Less than 0.7 nanograms %	0.7-2.5 nanograms %
Murphy-Pattee	Less than 2.9 mcg %	4-11 mcg %

HISTORICAL
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TWO GOOD REASONS WHY THE ROAD TO NORMALIZED THYROID STATUS IS SO SMOOTH FOR THE SYNTHROID PATIENT.

(1) The onset of action of T_4 is gradual. It has a long in vivo "half-life" of over six days. (Occasional missed doses or accidental double-doses are of le concern because of this factor)[1]; (2) since SYNTHROID contains on T_4, the potential for metabolic surges traceable to more potent iodides (T_3) is eliminated.

AS WITH ANY THYROID PREPARATION, CAUTIOUS OBSERVATION OF TH PATIENT DURING TH BEGINNING OF THERAPY WILL ALER THE PHYSICIAN TO ANY UNTOWARD EFFECTS.

Side effects, when they do occu are related to excessive dosage. Caution should be exercised in administering the drug to patient with cardiovascular disease. Re the accompanying prescribing information for additional data write Flint Laboratories.

Choose the Smooth Road ...to thyroid replacement therapy

ATIENTS CAN BE UCCESSFULLY AINTAINED ON A RUG CONTAINING HYROXINE ALONE.

hyroxine (T_4) is, as you know, e major circulating hormone roduced by the thyroid gland. $_3$ is also produced, in smaller mounts, and is active at the ellular level. For years it has been working hypothesis among ndocrinologists that T_4 is onverted by the body to T_3. In 970 this process, called deiodination," was demonstrated y Braverman, Ingbar, and Sterling[2]. $_4$ does convert to T_3, though the recise quantities are still being udied.

The conversion has been inically demonstrated during the dministration of T_4 to athyrotic atients. Their thyroid status is ormalized on SYNTHROID alone, et the presence of T_3 in these atients has been clearly shown.

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sodium levothyroxine)

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ynthetic thyroid drugs are an provement over animal gland oducts. Patients, even athyrotic ies, can be completely aintained on SYNTHROID (T_4) one. Thyroid function tests are sy to interpret since they are *edictably* elevated when the tient adheres to SYNTHROID. all synthetic thyroid drugs, NTHROID is the most onomical to the patient.

WHY DOES SYNTHROID COST LESS THAN SYNTHETIC DRUGS CONTAINING T_3?

Very simple. T_3 costs more to make synthetically than does T_4. So it is economically necessary for a synthetic thyroid medication containing T_3 to cost more than one containing T_4 alone. Synthetic combinations cost patients nearly 50% more than SYNTHROID[3] because the T_3 costs more to start with; also there is the additional expense of formulating a tablet containing two active ingredients.

1. Latiolais, C. J., and Berry, C. C.: Misuse of Prescription Medications by Outpatients, *Drug Intelligence & Clin. Pharm.* 3:270-7, 1969.
2. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T4) to Triiodothyronine (T3) in Athyreotic Human Subjects, *J. Clin. Invest.* **49**:855-64, 1970.
3. American Druggist BLUEBOOK, March, 1971.

OFFER:
Free TAB-MINDER medication dispensers to start or convert all your hypothyroid patients to SYNTHROID. Free information to physicians on role of thyroid function tests in a new booklet titled: "Guideposts to Thyroid Therapy." Ask us.

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Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) **Tablets** include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) **for Injection** is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose, preferably after breakfast. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) for **Injection** may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

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William Jensen, MD, Grand Rapids,
has been named delegate to MSMS from the Michigan Society of Anesthesiologists. Alternate delegate is Barry Smiler, MD, Detroit, while Ralph E. Bauer, MD, Detroit, was elected president of the society.

Ralph E. Lewis, Ann Arbor,
is new fulltime executive director of the Michigan Medical Schools' Council of Deans. Mr. Lewis has been associate program manager in postgraduate medicine and health professions education at the U-M.

Paul Lowinger, MD, Detroit,
traveled to Europe late in April to participate in the meeting of the Royal Society of Medicine in London (the subject was drug abuse) and to lecture at the Erasmus University School of Medicine in Rotterdam where he talked about radical psychiatry. Doctor Lowinger is adjunct professor of psychiatry at WSU and consultant to Lafayette Clinic and the Model Neighborhood Drug Abuse Program.

Norman D. Nigro, MD, Detroit,
is the recipient of the Michigan Cancer Foundation's "Distinguished Service Award for 1972." Doctor Nigro, head of colon and rectal service at Harper Hospital, was singled out for his outstanding leadership and commitment to professional education in the area of cancer of the colon.

Julien S. Priver, MD, Detroit,
has been appointed by the mayor to serve on Detroit's four-member board of health. Doctor Priver, who will serve a four-year term, is executive director and vice president of Detroit's Sinai Hospital.

Fred C. Sabin, MD, Marquette,
is new chairman of the Northern Michigan University board of control. Doctor Sabin will serve a two year term and has been a member of the board since 1967. He is a past member of the State Board of Registration in Medicine.

Two Michigan physicians,
are serving on national health advisory bodies. They are Donald J. Birmingham, MD, professor of dermatology and syphilology at Wayne State University School of Medicine, who is a member of the Safety and Occupational Health Study Section of the National Institute of Occupational Safety and Health; and Kenneth L. Krabbenhoft, MD, chairman, Department of Radiology, WSU School of Medicine, who is a member of the National Cancer Advisory Board of the National Cancer Institute.

new Santyl™ ointment (collagenase)

Indications: Santyl Ointment is indicated for debriding dermal ulcers and severely burned areas. In other types of necrotic skin lesions reports on the use of Santyl Ointment have been limited to clinical observations without controls.

Contraindications: Application is contraindicated in patients who have shown local or systemic hypersensitivity to Collagenase.

Precautions: The enzyme's optimal pH range is 7 to 8. Lower pH conditions have a definite adverse effect on the enzyme's activity, and appropriate precautions should be taken.

The enzymatic activity is also adversely affected by detergents and hexachlorophene and heavy metal ions such as mercury and silver which are used in some antiseptics. When it is suspected such materials have been used, the site should be carefully cleansed by repeated washings with normal saline before Santyl Ointment is applied. Soaks containing metal ions or acidic solutions such as Burow's solution should be avoided because of the metal ion and low pH. Cleansing materials such as hydrogen peroxide or Dakin's solution do not interfere with the activity of the enzyme.

Debilitated patients should be closely monitored for systemic bacterial infections because of the theoretical possibility that debriding enzymes may increase the risk of bacteremia.

The ointment should be confined to the area of the lesion in order to avoid the risk of irritation or maceration of normal skin.

A slight erythema has been noted occasionally in the surrounding tissue particularly when the enzyme ointment was not confined to the lesion. This can be readily controlled by protecting the healthy skin with a material such as Lassar's paste.

Since the enzyme is a protein, sensitization may develop with prolonged use although none has been observed to date.

Adverse Reactions: Adverse reactions to Collagenase have not been noted when used as directed.

Dosage & Administration: Santyl Ointment should be applied once daily (or once every other day in the case of outpatients) in the following manner.

(1) Prior to application the lesions should be gently cleansed with a gauze pad saturated in normal saline, buffer (pH 7.0-7.5) or hydrogen peroxide to remove any film and digested material.

(2) Whenever infection is present, as evidenced by positive cultures, pus, inflammation or odor, it is desirable to use an appropriate topical antibacterial agent. Neomycin-Bacitracin-Polymyxin B (Neosporin) has been found compatible with Santyl Ointment. This antibiotic should be applied to the lesion in powder form or solution prior to the application of Santyl Ointment. Should the infection not respond, therapy with Santyl Ointment should be discontinued until remission of the infection.

(3) Santyl Ointment should be applied (using a wooden tongue depressor or spatula) directly to deep wounds, or, when dealing with shallow wounds, to a sterile gauze pad which is then applied to wound. The wound is covered with sterile gauze pad and secured with clear tape or Kling bandage.

(4) Crosshatching thick eschar with a #11 blade is helpful. It is also desirable to remove as much loosened detritus as can be done readily with forceps and scissors.

(5) All excess ointment should be removed each time dressing is changed.

(6) Use of the ointment should be terminated when sufficient debridement of necrotic tissue has taken place.

Overdose: Action of the enzyme may be stopped, should this be desired, by the application of Burow's solution U.S.P. (pH 3.6-4.4) to the lesion.

How Supplied: Santyl Ointment contains 250 units of Collagenase enzyme per gram of white petrolatum U.S.P. The potency assay of Collagenase is based on the digestion of undenatured collagen (from bovine Achilles tendon) at pH 7.2 and 37° C. for 24 hours. The number of peptides cleaved are measured by reaction with ninhydrin. Peptides released by a trypsin digestion control are subtracted. One net Collagenase unit will solubilize ninhydrin reactive material equivalent to 4 micromoles of Leucine.

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30 North Jefferson Road
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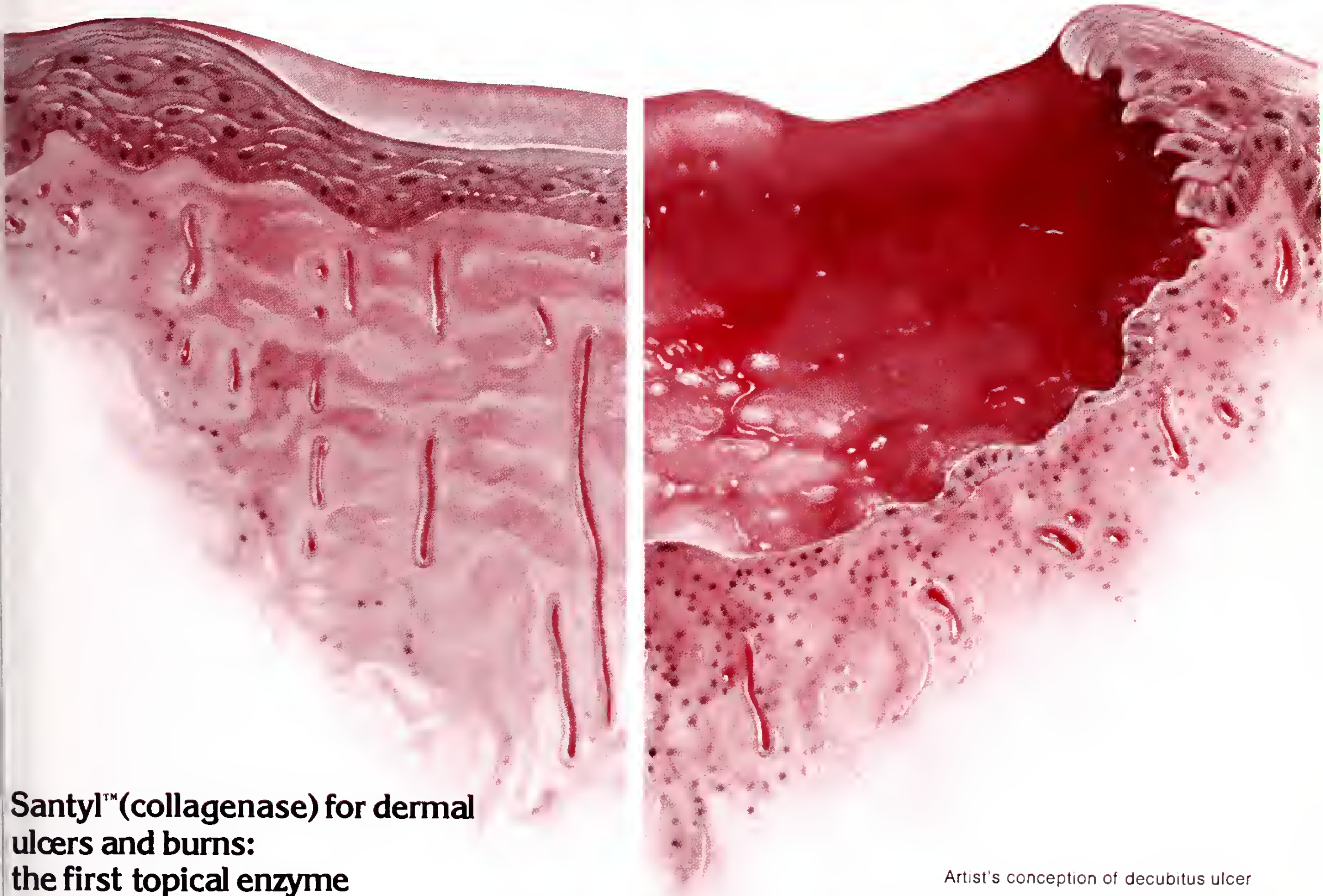
new **Santyl**™ ointment (collagenase)

"...it may prove to be the drug of choice for wound debridement."

Varma A O *et al*: *Surg. Gynec. Obstet.* 136:281, Feb. 1973.

To permit healing like this...you want to start like this.



Artist's conception of decubitus ulcer

Santyl™ (collagenase) for dermal ulcers and burns: the first topical enzyme

▸ to attack

native collagen, a substance that is ordinarily resistant to all common topical enzymes used in wound debridement

▸ to dissolve

the strands of tissue that "anchor" necrotic debris and burn eschar to the wound surface

▸ to effectively remove

the debris that hinders healing...with simple, once-a-day application

I treat patients with dermal ulcers and burns, and I would like to receive:

☐ clinical reprints and scientific information on Santyl.

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The historical background of acupuncture

By Raphael Cilento MD, FRCS
Northville

Chinese medicine and philosophy are bound in an alliance which has been validated by thousands of years of practical application. Their very persistence makes them an important social force and since they are responsible for the welfare of about one-sixth of the world's population, to dismiss even a part of them as insignificant is unrealistic.

While Western philosophy tends to rationalize our medical practices as being the best and most progressive, without a true knowledge of the background upon which Oriental medical care is projected, there is no validity in dismissing any phase of it as unscientific.

Legend claims that men existed in North China for 300,000 years, since P'an Ku, the "All Father," made his appearance on earth. Certainly archeological studies support the presence of modern-type man for at least 50,000 years, while it is known that Chinese culture spread from the North Coast throughout South East Asia and Japan at least 4,500 years ago.

It is held that the Hsia dynasty (2205-1766 B. C.) begins Chinese history. Fu Hsi, "The Archer," father of the modern art of cooking and inventor of the bow, is said to have lived about 3,000 B. C. He was succeeded by Shen Nung, "The Farmer," to whom is credited the origin of modern medicine. He began the modern era of the agrarian community (as opposed to the previous hunter-nomad society) by inventing the plow and setting rules for producing "the five grains" (or cereals). He established rules of dietetics and health and treatment for certain illnesses, based on the use of antidotes for specific poisons.

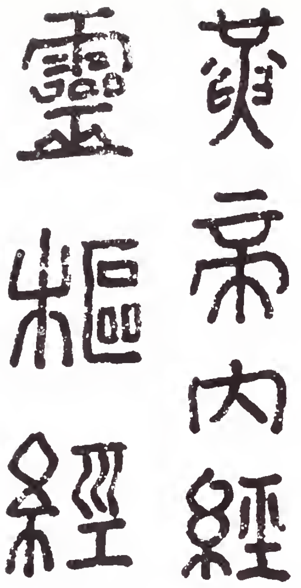

Fig. 1. Title page of the YELLOW EMPEROR'S NEI CHING.

The world's oldest book of medicine, the Nei Ching, propounds in its first part (Su Wen) a philosophy of living which is just as relevant today as it was then, in the time of the Emperor Huang Ti and his physician, Ch'i Pi, nearly 5,000 years ago.

According to the Su Wen, by avoiding intemperance and leading a simple, peaceful life, the mind maintains its integrity and the body cannot easily be attacked by disease. The same tenets - e. g. Mens sana in corpore sano - are the basis of our modern medical advice for rewarding survival.

The dualistic theory ascribed to the Emperor Fu Hsi, the Philosopher, was propounded about 5,000 years ago. This postulates two opposing energies, Yang and Yin, each existing *in relation only to the other,* which wax and wane to obtain a constant balance. In the framework of the Tao, the divine law controlling relations between the "macrocosm" (the total environment) and the "microcosm" (man, the replica of the macrocosm), Yang and Yin represent balancing forces.

For Example:

	YANG			YIN
Numbers	one and odd			two and even
Colours	Black			White
	Sky and Sun	Large Bowel	Lung	Earth and Moon
	Masculinity	Small Bowel	Heart	Feminine
			Spleen	
	Activity	Gall Bladder	Liver	Passive
		Triple Warmer	Blood	
	Splendour	Bladder	Kidney	Plain
	Hardness			Soft
	"Analogue".			
	Sympathetic Nervous System			Parasympathetic Nervous System

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Scientific articles

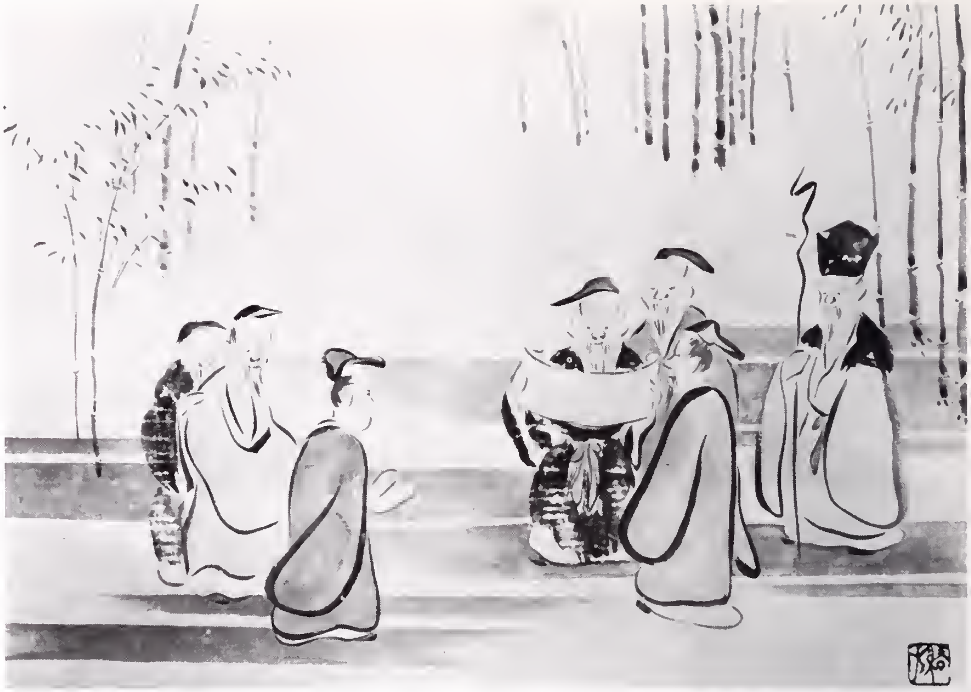

Fig 2. A contemporary study of the "Seven Wise Men" painted in 1,700. The physician is second from the right. This is by Korin after a classical Chinese concept from the Sung period (from the author's collection).

The other major ancient school of philosophical theory related five elements—wood, fire, earth, metal and water, five planets, five seasons, and five colours. Anthropomorphic evaluations were based on "wood" types, "fire" types, and elements. Eventually the two schools merged.

Chinese medicine seeks to maintain or restore the balance between the two principles, much as Western medicine does, despite the basic philosophical differences of approach.

Acupuncture, which is a definite specialty within the framework of Chinese medicine, was usually classified as hypnotism or charlatanism in the West. Westerners cannot rationalize into scientific thought the removal of pain or the cure of disease by sticking a needle into a patient and twirling it around or giving electric impulses through it.

As with Yoga, the basic philosophy and actual practice should lead to some enlightenment in our world and the extraction of much new knowledge. We all too readily accept the old maxim "Orthodoxy is my doxy; Heterodoxy is any body else's doxy" in all our social contacts, and the desire for "conformity" and "belonging" is the major social force in the United States of America today.

Chinese Basic Philosophy

1. Health is the balance of two opposing forces in the body.
2. These forces also exist in all nature and flow along precise lines in the body as "energy." (Ch'i).
3. In health these forces are balanced.
4. If the balance of energy is disturbed, disease results, which is reflected in "the pulses."
5. The maintenance of the balance is even more important to the physician than the treatment of the disorder (to maintain harmony).

Thus the physician's responsibility still remains the same since the early nomadic tribes' "Shaman" or "Medicine Man," chose the camping site, checked out drainage levels and supervised waste disposal as his prime duties.

Louis XIV sent Jesuit priests to Peking and produced Harvieu's work on the "pulse studies" as practiced in China (1671) since then there have been hundreds of books written and "acupuncturists" were much in vogue in Europe. Laennec was interested in the rationale of the procedure as were many of his contemporaries, but George Soulie' de Morant (French Consul in Shanghai) made the first accurate elucidation of the procedure in writing. In 1908 he was made "Master Physician." In 1928 he published a study of Pulse Diagnosis after treating several patients with acupuncture at demonstrations for physicians in several French hospitals with dramatic benefit to the patients. His works on "True Chinese

Acupuncture" (1934) and "Chinese Acupuncture" (1939) became the standard textbooks on the subject, and were acclaimed all over the world.

Early Chinese Medicine

Huang Ti, "The Yellow Emperor," and his ministers recorded all the medical knowledge available and produced the Nei Ching about 2,500 B. C. Huang Ti was himself a great acupuncturist. The Nei Ching is in two parts, Huang Ti Su Wen and Ling Shu, an acupuncture textbook. This work is still the inspiration of major medical philosophical thought in China, while Western methods have been incorporated into the practical application of the physician's armamentarium.

The interesting and significant point is that the Orient collected and evaluated all our scientific knowledge, making enormous original contributions in every field (especially in Japan), retaining what was best, and incorporating it into its own system. In China this is particularly true, but not surprising when one considers that even in 624 B. C. there was a 349-member Court of Examiners who granted medical diplomas by examination. This was an organ of the state!

In the Cultural Revival (700-900 A. D.) medicine was officially divided into four specialties under the T'ang dynasty;

A.
    1. Pulse Specialists
    2. Childrens Specialists
    3. Mouth, Nose and Throat

B.
    1. Acupuncturists

C.
    1. Masseurs
    2. Bone Setters
    3. Physical Therapists and Breathing Specialists

D.
    1. Prayer Specialists
    2. Diviners and Sooth Sayers
    3. Spell Makers

The final court of appeal when all else had failed, then as now!

By 1,000 A. D. a special school of acupuncture was founded, and it was traditional for the Emperor to become highly proficient in this art.

Western culture until only 300 years ago was permeated with magic and occultism, and a confused relationship in regards to all medical matters relative to other sciences or arts. The same state still exists in China (according to our Western views) but one must realize the basis upon which Oriental medicine is built. The emphasis there has changed remarkably in the last few years as our scientific discoveries have been incorporated. But spiritual and corporeal unity still remain indissoluble in Oriental culture, and certainly this is a more realistic outlook with greater potential for the betterment of our health than much of our "fractionated medicine."

Dissection of human cadavers (convicted felons) was allowed under the Sung Dynasty about 1,000 A. D., but since a robber could not possibly be the same as a person of merit there was little development of anatomy *per se.* This dramatically illustrates the basic difference in philosophy between east and west as regards medicine and the patient.

Under the Sungs in 1076, the Su Wen was the standard textbook for the Imperial School for Medicine and Acupuncture and more and more texts on acupuncture appeared. Despite violent social upheavals in the Sung period, to 1368, acupuncture spread widely and by the end of the 16th century another compilation of medical knowledge appeared, the "Chen-Chiu Ta-Ch'eng" (compendium of Acupuncture and Moxibustion) which included parts of all known works from the Nei Ching onward and ran to 10 volumes. This was during the fruitful and peaceful Ming Period (1368-1643).

In 1556, Sin Ch'ong Fu published "Ancient and Modern Generalities" in one hundred volumes, of which two dealt with acupuncture, followed in 1575 by the eight volume "Doorway to the Study of Medicine" with one volume on acupuncture.

A study of the 1679 edition of Chen-Chiu Ta-Ch'eng reveals nine ancient acupuncture needles designed for special functions, ranging from an arrow shaped brad-awl type to a long thin needle with beveled point. The thicknesses varied from a hair to about three millimeters, but all had beveled points and cylindrical bodies, except one where the body was three sided like an epée. The materials used included stone, porcelain, gold, silver, and stinless steel. The value of gold and silver were discussed at length by the French school with relation to hydrolytic action in the tissues and variations in electric potential. (However, stainless steel is usually used today.) Gold and silver needles were first used in China only for important clients early in the Sung dynasty.

Concepts of Function and Diagnosis

The Ch'i

Chinese have long identified energy and matter as the same thing in different forms. The Ch'i is the energy related to the microcosm. It is intangible but varies in degree with individuals, leaving the "energy masters" (lungs) at dawn and returning next morning. This makes the propitious time for operations on the various organs subservient to the cyclic Ch'i strength, with it or against it depending on the acumen of the physician.

3 a.m.	-	5 a.m.	lungs
5 a.m.	-	7 a.m.	large bowel
7 a.m.	-	9 a.m.	stomach
9 a.m.	-	11 a.m.	spleen
11 a.m.	-	1 p.m.	heart
1 p.m.	-	3 p.m.	small bowel
3 p.m.	-	7 p.m.	urinary tract
7 p.m.	-	9 p.m.	blood circulation
9 p.m.	-	11 p.m.	"Triple Warmer"
11 p.m.	-	1 a.m.	gall bladder
1 a.m.	-	3 a.m.	liver
3 a.m.	-	5 a.m.	lungs

The Pulses

These studies allegedly were by Pien Ch'ueh.

There are over 150 books on diagnosis by "the Pulses" written in China, some of which were used in Persia around the dawn of the Christian era. Even now "traditional" Chinese physicians may take two hours solely examining the pulse and its aspects - given up to 47 individual characteristics.

"The Fourteen Pulses" of the radial arteries are inseparable from the acupuncturist's art. By refinement over the centuries these pulses are now the only ones used although the carotids, femorals and dorsales pedis have all been used in antiquity.

Treatment is based on "dissipating (sedating) or "stimulating" the excess of Yin or Yang, but "the Pulses" are never to be used alone as they can be misleading to even the experienced physician. This principle of the essential nature of a full history and clinical evaluation coupled with "the Pulses" goes back to the Yellow Emperor, Chi Po, and the Su Wen. The importance of psychic factors in acupuncture is stressed in the same work.

The control of energy in the body according to the ancient Chinese was vested in 12 rivers (or meridians) flowing into the Seas of Marrow, Blood, Energy and Nourishment, which were prevented from flooding by an extra eight canals which balanced the Seas and allowed a reserve to accumulate (as energy) in extra meridians which released into the circulation as required. Decompensation of these systems caused illness. *Cure* resulted from redistribution of the life energy (or Ch'i) and was accomplished by remote point puncture subject to certain rules.

Ching

These are the constant but invisible tracks followed by the Ch'i, often known as the "meridians" since Soulie de Morant's publications. They form 12 symmetrical paired pathways on the body along which the Ch'i courses, but only between a Yang and Yin organ.

Six Yang meridians on the outer side of the limbs are responsible for transforming energy from external sources and correspond to Yang organs.

Six Yin meridians store the life energy and lie on the inside of the limbs. Each pair is joined by a connector channel at both extremities.

Two further meridians exist running vertically between the two sides of the body—Jen-Mai (conception) and Tu-Mai (the governor), which are independent of the others but communicate with each other.

Finally, the six "crossing meridians" are recognized, each corresponding to points on the main meridians but with their own course.

The Points:

The skin is the interface between microcosm and macrocosm. Where there is a disturbance between them the skin has a constant point to which the affected organ or function refers pain, always the same for a specific disorder. To restore the balance, action at these points is necessary. The Nei Ching gives 365 points, corresponding to the days of the year, while Soulie' de Morant gives 618 on the double meridians; plus 24 on Jen-Mai and 27 on Tu-Mai making 763 in all. Chinese and Japanese authors add a number of extra meridian points and a varying number of new points on whose total there is disagreement. In all, up to 1,000 points are recognized.

1. *Master Points:*

   Varying the stimulation of these points is said to enhance the "stimulation" or "sedation" to another point.

3. *Lo Points:*

   These act on "coupled" organs—(e. g. heart and small intestine) by equalizing their energy.

4. *Compliment or Approval Points:*

   These lie on the urinary bladder meridian only and enhance the action of the specific point.

5. *Stimulation or Tonification Points:*

   These stimulate healing in a corresponding function or organ.

6. *Sedation Points:*

   These decrease the Ch'i in specific organs.

Verification of the Points

Yang Tsie in about 1225 verified the changes in both pulse and organ by exposing the liver in human subjects and stimulating the specific point. There is still documentation of these experiments

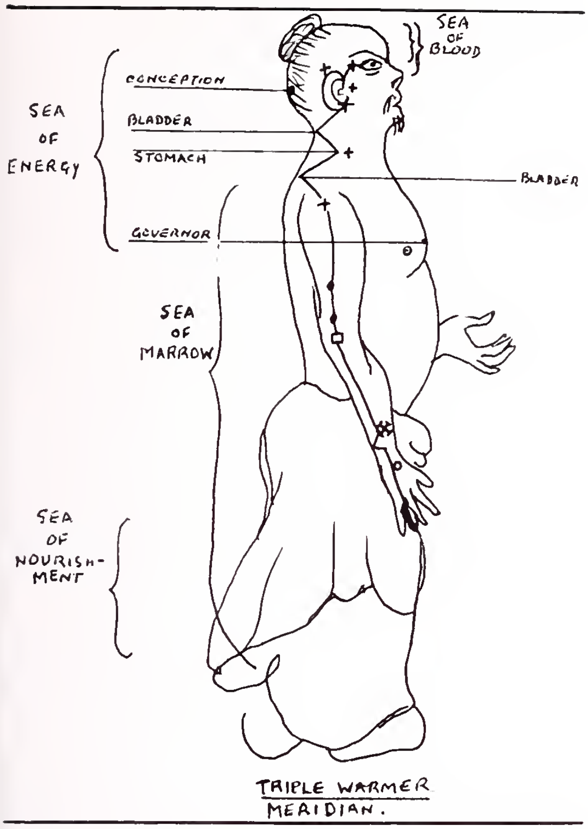

Fig. 3. An attempt by the author to combine the concepts of the old and new theories. Point symbols indicate, (from above), Connecting, Tonification, Sedation, Forbidden and Lo points on the meridian.

in the original. Convicted felons were the subjects of these studies.

Antiquity recognized 66 master points, six for each Yang and five for each Yin "Ching." These points act on all meridians and are confined to the limbs, combining the effects of several other points. One point influences most other points.

No anatomical verification at dissection was discovered by Professor Riviere of the Paris Faculty of Medicine, but claims have been made that the meridians can be traced by the low electrical resistance along their course, using a variety of "electronic" gadgets. Several types of "sensors" with lights as indicators are still used in some European practices.

Professor Huard of the French Academy of Sciences has stated that the meridians are imaginary and correspond to the Indian "nadis." This is the view held by most Chinese physicians today. Some writers also identified Yang meridians with nerves and Yin with arteries.

Centuries of experience have resolved certain groups (three Yang and three Yin) inside the meridians which must be needled in pairs and have marked therapeutic value. There are also 36 independent points.

Obviously, a tremendous number of combinations and permutations exist and such was the magnitude of the field that certain physicians devoted their whole lives to the study of one particular point!

Historical Techniques and Tools

Before Ch'i Po, primitive forms of treatment such as piercing the painful areas, then later certain adjacent areas, were used. Then as experience accumulated the meridians were defined and modified to the time when they were stabilized by the Nei Ching. The original concept of needling stems from the legend that pain was often relieved or a disease cured after a warrior received a non-fatal wound from an arrow.

Acupuncture needles are known to have been made originally from stone, but after the Nei Ching eight of nine needles used were made only of iron from a horse's bit and only on license from the Emperor. The longest needle was copper and was heated before use to restore the depleted Ch'i. Gold and silver needles probably came into use as a social symbol.

Modern needles vary from 1 cm. to 15 cm. in length and are slender stainless steel cylinders with a coiled spring embracing the held end. Some French acupuncturists state; "the thicker the needle, the better their effect," and the variety of shapes is endless—from a spiral to a type of short flat-headed nail to be taped in place for varying periods. For thousands of years the exact style has been the subject of controversy, often acrimonious debate.

Modern Techniques Compared to Ancient Techniques

There are a number of important points which still have significance after several thousand years. It can be readily seen that quite a few of those listed below are taken from "The Yellow Emperor's Classic" and are sound medical sense.

1. *Applicability*

   Exclude certain ills where relief of pain would mask another lesion and confine its use to functional problems as opposed to surgical lesions. Hence neuralgias, tics, rheumatism, gout, eczema, hay fever, heart and circulatory disorders and a host of others related to various system malfunctions are the field of choice. Acupuncture's function for anesthesia is now in the forefront of medical interest.

2. *Restrictions*

   Certain tenets of the Nei Ching are still taken into account in the refusing of acupuncture. Huang Ti advised against it as follows:

   "When he is too hot.
   When he is sweating profusely.
   When his pulse is greatly disturbed.
   When he is drunk or angry.
   When he is overtired, hungry, breathless or has eaten too much.
   When he is in the grip of a great fear."

   It is also usually considered inadvisable in pregnancy.

3. *Number and Duration of Treatments*

   In 1798 the "Chen-Chiu I Sis" recommended the restriction of needling to four per treatment although usually six to eight are used these days in the East. Needles are left in place for periods varying from seconds to minutes. Ancient methods dictate short periods for stimulation and longer periods for sedation. Needles were usually inserted to a depth (depending upon the depth of the underlying tissues) of 1 cm. to 2 inches.

4. *The Laws of Needle Insertion*

   The Pu Hsieh dictates the speed and direction of insertion of the needle in relation to skin surface and the meridian in general. Further rules as to the motion when the Ch'i has been attained at the correct depth govern the manipulation from then on. Twirling, up and down, sideways, back and forth and in a circle are just some of the maneuvers which are performed at different speeds.

The acceptance of the procedure and the explanation of the basic philosophy were stressed from antiquity, and are still an important factor in modern practice in China.

An interesting parallel can be drawn with the preparation for "painless natural childbirth" which has been a major obstetrical force in China especially during the last 15 years. Following the work of Grantly Dick Reed in Europe and Phyllis Cilento in Australia the French School made great strides toward stabilization of this practice and was closely involved with the Chinese progress, where 400,000 births following this method were recorded by 1960.

A well prepared patient enters the operating room in modern China calm and confident, having had at least one week of psychological preparation and sedated only for sleep the night before surgery.

During the procedures an I. V. containing 50 mgm. of Demerol in 1,000 cc. of glucose or glucose saline is administered by slow drip. The patient usually is able to walk from the operating room and function independently following surgery.

In our own experience at this Research Unit this seems an important factor. Our own patients (in minor procedures) will form the subject of another publication.

SUMMARY

A brief history of Chinese medicine as applicable especially to acupuncture is offered in an attempt to enlighten the background of ignorance regarding this subject in the Western medical world. Ancient beliefs and modern techniques are briefly outlined. The field of Chinese herbal medicines has not been included as it is as vast and complicated a subject as acupuncture—if not more so. It does however illustrate once again the tremendous experience and massive accumulation of ancient knowledge representing medicine in the Orient into which has been absorbed the full armamentarium and impedimenta of the Occidental world, without altering the basic unity of soul and body which is so essential to complete medical care.

Oriental medicine should fill us with humility in the face of its grandeur and antiquity, no less than for the extraordinary adaption and use of modern materials, to implement a massive adequate coverage of a huge population without regard to social station, money or personal glory.

(Continued on page 357)

Drug Detection

A service performed by the Michigan Department of Public Health

By J. R. Howenstine, PhD
Lansing

The detection of drugs is not a service provided by the Michigan Department of Public Health wholly as a result of contemporary drug abuse but is one which has been provided for about 40 years.

The very first case in the laboratory files at the State Record Center in Lansing goes back to 1933 when in a nearby county a subject apparently hung by a bathrobe cord to a hinge of his bedroom door. The flimsy nature of the cord made the officers suspicious that the case was not a suicide. The Coroner and Sheriff accordingly ordered that an examination for poisons be conducted. Specimens of stomach, kidney, liver and brain were submitted to the state health department laboratories in Lansing where such examinations were routinely performed. A chemical analysis of the specimens in this case showed the presence of strychnine and luminal (phenobarbital). As a result of these findings, the laboratories were able to provide valuable assistance to the law enforcement agencies investigating the case.

The dependable scientific expertise demonstrated by chemists employed by this department on medico-legal cases had considerable influence on the members of our state legislature. So much so that they passed Act 62 of 1941 which officially established the state crime detection laboratory in the Michigan Department of Public Health. The purpose of the act was to provide all law enforcement agencies with facilities for examinations and analyses in matters of a criminal nature to the end that the laws of this state may be enforced and violators brought to trial.

Doctor Clarence Muehlberger, a well known and recognized toxicology expert and crime laboratory scientist was brought in from Chicago to direct the activities of the laboratory in July, 1941. All kinds of cases began to arrive at the laboratory and the case load soon began to rise. In the last six months of 1941, 76 cases were submitted and the following year the number increased to 206.

There has been a steady increase in the demand for services and the number of cases submitted to the laboratories each year. In fiscal 1971-72, 6,052 cases were investigated by crime laboratory personnel. Between July 1941 and July 1972, the laboratory processed a total of 80,453 cases.

Not all of these cases involved drugs. The state crime detection laboratory is organized in the Michigan Department of Public Health as the Division of Crime Detection in the Bureau of Laboratories. The bureau chief is Kenneth Wilcox, Jr., MD and the division chief is Edgar Kivela, PhD. The Division is organized into the Toxicology, Pesticides and Criminalistics Sections.

The Criminalistics Section has little to do with drug detection. It performs examinations of arson evidence, fibers, paints, explosives, hairs, seminal stains, blood stains, and general identification of almost any natural or man-made product other than drugs or poisons.

The Pesticides Section was established through a contract with the U. S. Public Health Service in 1965. The work of this section is directed toward determining the significance of pesticides as a health hazard and the sources of pesticides from the environment. It is only rarely that this section becomes involved in crime laboratory casework.

Drug detection in the Division of Crime Detection is limited to the Toxicology Section. The Section is subdivided into two units, the Toxicology Unit and the Drug Identification Unit.

The Toxicology Unit makes analyses of body fluids and tissues for drugs and poisons. It also tests materials submitted for common poisons such as strychnine, arsenic, mercury, cyanide, fluoride, nicotine, and formaldehyde. Analysis of blood and urine for methyl, ethyl, or isopropyl alcohol and acetone is the most frequent type of analysis performed. The Drug Identification Unit analyzes tablets, capsules, powders and liquids for drugs covered under the Michigan Controlled Substances Act of 1971. These drugs include the narcotics, hallucinogens, stimulants and depressants. The frequency of positive findings of various drugs covered under this act during the first seven months of 1972 is shown in **Table 1**.

One drug now presently covered under the Michigan Controlled Substances Act is becoming an increasing drug abuse problem. This drug is

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Table 1. - Frequency of positive findings of various drugs covered under the Michigan Controlled Substances Act of 1971 in preparations submitted January through July, 1972.

SUBSTANCE	No of Positive Findings	Percentage of Drug Identification Cases
Marihuana	452	38
L S D	304	25 5
P C P (phencyclidine)	129	10 8
Barbiturates	125	10 5
Heroin	101	8 4
Amphetamines	83	6 9
Methamphetamines	32	2 6
Cocaine	14	1 0
Codeine	5	less than 1 0
Methadone	4	less than 1 0
Morphine	3	less than 1 0
Ritalin	3	less than 1 0
Demerol	1	less than 1 0

Many of the 1,190 drug identification cases received during this seven month period gave a positive finding for more than one kind of substance It should be noted that the laboratory is not capable at the present time of analyzing body fluids or tissues for any of the three most frequently found substances listed in the table

methaqualone, a hypnotic. The laboratory has received from two to eight cases per month this year involving methaqualone alone or with other drugs of abuse. This year the drug has been found in 15 cases of suspected drunk driving either alone or with alcohol. Analysis of materials for prescription drugs is also made in cases of possible violation of the state pharmacy laws.

Although the Division of Crime Detection has assisted law enforcement agencies in attempts to reduce drunk driving on Michigan highways since the laboratory's inception, its role was greatly expanded with the passage of Michigan's Implied Consent Law, Act 253 of 1967. This statute authorized the Department of Public Health to set standards for blood alcohol testing. As a result the Division not only analyzes blood and urine specimens for alcohol content, but also supervises, trains and certifies police officers to conduct Breathalyzer tests on subjects arrested for driving while under the influence of alcohol. By conducting 40 hour training schools on a monthly basis for a period of nine months out of the year, the Division supplies an adequate number of certified operators (approximately 1,500) at sufficient locations throughout the state to provide breath alcohol testing capability to any arrested subject within about 30 minutes from the time of arrest. It is currently of interest that data collected by the Department of State Police show that the number of persons tested during the first seven months of 1972 is 30% greater than the number tested during the same period in 1971. Of these, 92.5% who were tested by Breathalyzer showed a blood alcohol value of 0.10%, or higher, the level presently set for presumption of driving under the influence. The number of subjects tested in 1972 through July was 16,037.

The crime laboratory provides some drug detection services which are not directly related to law enforcement. These services include the analysis of blood, urine or stomach contents for drugs or poisons in cases where a physician does not have these services available to him and needs the information in order to treat a patient. This service is limited in value because of time and distance factors. The laboratory has attempted to assist personnel of various hospital and clinical laboratories to establish facilities in order to perform the simpler and more frequent toxicology tests so that the physician may rapidly diagnose the more common type cases.

The Division of Crime Detection has, since the end of February of this year, provided laboratory testing for the Department's Drug Anonymous Program which is coordinated by Dennis Seeley, Division of Chronic Disease Control. The goal of this program is to provide information in an anonymous way to people so that more intelligent decisions can be made about using drugs with a reduction of unexpected toxic reactions. The service has been generally limited to the counties of Ingham, Van Buren and Clinton thus far and has operated through local health departments and crisis centers. In such cases the laboratory attempts to report back to the submitting agency within a week the type of drug, i.e., narcotic, depressant, stimulant, hallucinogen or marihuana. In some cases identification of the drug is conducted to a greater extent and the report may indicate that the narcotic is heroin or the hallucinogen is LSD. In the case of heroin highly potent concentrations are differentiated from the usual street concentrations and where indicated the drug may be screened for substances such as rat poison. Color photographs are taken of the illicit drugs as an aid to the submitting agencies in handling drug problems. Feedback from the program over the first 15 weeks indicated 761 people benefited from the service.

Because of the increased demand for competent crime laboratory and drug detection services the Michigan Department of Public Health in a joint plan with the Department of State Police is attempting to provide these services both centrally and regionally throughout the State. Health Department personnel are assigned to laboratories in not only Lansing but Warren and Holland. The addresses of the three laboratories are as follows:

(Continued on page 357)

A new look at an "old friend" — upper gastrointestinal hemorrhage

By John P. Papp, MD, F.A.C.P.
Grand Rapids

Hematemesis is a terrifying experience for the patient. It demands prompt investigation as to the site of bleeding if we are to improve the greater than eight percent mortality that the past decade of "better treatment" has shown. Despite improved radiological technique with barium and mesenteric arteriography in the 1960's, no advance in lessening mortality was achieved. With the development of longer, flexible fiberoptic endoscopes as made by Olympus, ACMI, and Machida, it is now possible to view the esophagus, stomach, and duodenum and actually see the lesion or lesions that are bleeding.

The practice of waiting until the patient is "stable" and then obtaining an upper gastrointestinal (UGI) x-ray has a number of drawbacks and has probably contributed to the lack of improvement in mortality. First, one doesn't know what he is treating. If massive bleeding occurs, where will the physician advise the surgeon to look? Secondly, lesions such as esophagitis, erosive gastritis, esophageal tears (Mallory-Weiss syndrome), and mucocutaneous disorders associated with gastrointestinal bleeding are not recognized by barium meal radiological examination. It is well known that stomal ulcers are difficult to show radiographically.

If the above reasons are not sufficient to suggest that x-ray examination of the UGI tract is not enough in the actively bleeding patient, the following reasons lend added support: 1) from five to 33 percent of duodenal ulcers are not demonstrated by x-ray[1-3]; 2) bleeding may be so active that the stomach will be partially filled obscuring gross lesions; 3) a clot of blood may be misinterpreted as a filling defect; 4) the patient may be in shock and not fit for transfer to the x-ray department: 5) lastly, but of most importance is that x-ray can only demonstrate whether or not a lesion is present and can only infer that it is a lesion which *might* bleed. Palmer found in his series of 1,400 cases of UGI bleeding that 40 percent had some other source of bleeding than that demonstrated by x-ray.[4]

Since x-ray has limitations in acute bleeding, it is important to ask what are the causes. Palmer[4] lists them as follows: 1) duodenal ulcer; 2) esophageal varices; 3) gastic ulcer; 4) gastritis; 5) esophagitis; 6) Mallory-Weiss syndrome; and 7) marginal ulcer. Esophagitis, gastritis, and the Mallory-Weiss syndrome accounted for 24 percent of cases much as Gordon, et al, have reported.[5] Zollinger[6] reports duodenal ulcer as the most common cause followed by gastric ulcer, hiatus hernia, neoplasm and vascular lesions.

Table I
Mucocutaneous Syndromes
Associated with Gastrointestinal Bleeding[5]

1	Osler, Weber, Rendu disease
2	Universal angiomatosis[8]
3	Blue rubber bleb nevus syndrome[9,10]
4	Multiple phlebectasia[11]
5	Amyloidosis
6	Pseudoxanthoma elasticum
7	Ehlers-Danlos syndrome
8	Homocystinuria
9	Polyarteritis
10	Degos' disease[12]
11	Neurofibromatosis
12	Peutz-Jeghers syndrome
13	Kaposi's sarcoma
14	Carcinoid syndrome

Prior to treatment, it is still important to obtain a history and to do a physical examination. A few succinct questions must be asked. Has the patient had an UGI bleed before? Has he had black tarry stools, bright red rectal bleeding, bright red or "coffee-ground" emesis? Has he been drinking alcohol or taking any medication, especially aspirin? Is he a bleeder? Chandler, et al,[7] found that the impression obtained after a history and physical examination in an acute bleeder was correct in only 42 percent of patients. It should be stressed at this point that if the patient does not have a hematemesis at the time of examination, the burden of proof that the patient has not bled lies with the physician.

A rapid but essentially complete physical examination should be done with attention to liver size, whether "spider angiomata" are present, ascites, "liver palms" splenomegaly, mucosal pigmentation, neurofibromas, and telangiectasia. The latter three findings are mentioned to alert the physician to mucocutaneous syndromes associated with gastrointestinal hemorrhage (**Table 1**).

Initial approach to treatment is much the same as the treatment for any serious blood loss problem.

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A large bore catheter should be used and the subclavian vein is preferred as the intravenous site. Blood from the catheter for type and cross (six units), pro-thrombin time, partial thromboplastin time, clot retraction, hemoglobin, hematocrit, leukocyte count, platelet count, creatinine, and blood sugar must be obtained. A central venous catheter should be placed. A large nasogastric or Ewald tube should be introduced and the stomach lavaged with ice water. Careful notice should be given to whether blood is present and its character. An electrocardiogram should be taken. Hourly urine output should be observed and kept at greater than 25ml per hour. Palmer[4] feels that a silent myocardial infarction, unrecognized renal disease, and diabetes mellitus play a particularly important role in contributing to response of resuscitation.

After the above procedures have been done to monitor the patient, endoscopy should be performed. I use the GIF Olympus flexible fiberoptic endoscope with an end-on viewer. It is 100 cm long and can visualize the esophagus, stomach, and duodenum to the third portion without any blind spots. The cold light source avoids mucosal burns and the high intensity tungsten bulb provides excellent lighting for still and movie camera filming. With this instrument, one can now inspect the proximal UGI tract and record by observation, filming and biopsy, if necessary, the bleeding site. Washing with saline under direct vision with two atmospheres pressure can also be done if deemed necessary for cytological interpretation.

Halmagyi[13] felt endoscopy was helpful in 42 percent of 425 patients with UGI hemorrhage. However, it should be noted that by endoscopy he meant using a gastroscope. Also, 41 percent of the patients were bleeding from a duodenal ulcer. Zollinger[6] has not been impressed by endoscopy in evaluation of acute UGI bleeding. However, Baird[14] found that endoscopy established the site of bleeding in 88 percent of 155 cases. whereas x-ray did so in 66 percent of cases. Walls, Glanville, and Chandler[15] found that gastroscopy alone improved upon x-ray diagnosis (66 percent) by 12 percent. They stressed that the common finding of an esophageal hiatus hernia should not be considered the site of bleeding unless actually observed. Belber[16] found in 200 consecutive UGI endoscopic evaluations in patients having a concomitant UGI x-ray, 59 patients with a duodenal ulcer. Fifty-five duodenal ulcers were seen by endoscopy and 42 by x-ray.

In summary, all of the endoscopic, clinical, and x-ray studies reported above with the exception of Belber's report have been correlated without the benefit of being able to clearly and consistently evaluate the duodenum, which is the most common site of UGI bleeding. With the development of longer and more refined end-on and side viewing flexible fiberoptic endoscopes, a new and exciting diagnostic advance is now available in the patient with UGI hemorrhage. There is no substitute for *seeing* the bleeding point.

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The unique cardiotonic properties of glucagon

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Synopsis

The cardiovascular response of five normal young men to an intravenous bolus of glucagon, 45 mcg/K body weight, was noninvasively measured. Significant increases in both the rate corrected electromechanical systolic interval (QS_2I) and rate corrected left ventricular ejection time (LVETI) were observed within 10 minutes after administration of this drug ($p < 0.05$). A slight prolongation of the rate corrected pre-ejection period (PEPI) was also noted at five minutes in conjunction with a small decrease in PEP/LVET. The latter is assumed to reflect a modest inotropic effect of glucagon which is overshadowed by prolongations in the other systolic time intervals. This is in striking contradistinction to the response of these indices to other inotropic interventions such as digitalis and catecholamines which shorten PEP, QS_2I, and LVETI.

This is the first report detailing the unique response of systolic time intervals to glucagon emphasizing the difference in these parameters as compared to other positive inotropic agents.

Glucagon
Inotropism
Systolic time intervals

Glucagon's inotropic effect and ability to powerfully stimulate the adenyl cyclase system[1–4] have been compared to epinephrine which shares similar properties.[4-6] However, the fact that the myocardial effects of epinephrine can be blocked by propranolol[3] and other beta blocking agents[7] clearly indicates that its influence is mediated by a receptor site different from that responsive to glucagon which cannot be blocked by these agents. Additionally, evidence has been accumulated in our laboratory to suggest that the cardiotonic effect of glucagon differs measurably from that of catecholamines notwithstanding the clear demonstration by Glick, et al, that its inotropic effect on the cat papillary muscle and by Parmley, et al, that this effect on the human myocardium is similar to the effects of epinephrine.[3,8] This cardiotonic difference is reported herein.

Methods and Materials

The acute effects of an intravenous bolus of glucagon in a dose of 45 mcg/K body weight were measured in five normal adult men whose ages ranged from 29 to 32.[9] All were determined to have a normal cardiovascular apparatus by two observers prior to the study. Employing the Cambridge MC IV multichannel photographic recorder, simultaneous phonocardiograms, electrocardiograms and external carotid pulse traces were obtained prior to and five, 10, 15, and 20 minutes after the initiation of intravenous administration of glucagon which was administered over one minute in the dose indicated. Heart sounds were recorded with a Cambridge microphone characterized by a flat response from 20 to 2000 HZ.

The carotid artery pulse was obtained utilizing a piezoelectric crystal transducer.

The following systolic time intervals were obtained by the method of Weissler, Harris and Schoenfeld:[10] the electromechanical systolic interval (QS_2) which was measured from the onset of the first QRS deflection to the first high frequency vibration of the aortic component of the second sound; the left ventricular ejection time (LVET) which was measured from the onset of the upstroke of the carotid artery pulse trace to its incisura; the pre-ejection period (PEP) which was obtained from the difference between the QS_2 and the LVET; and the ratio of PEP to LVET. With the exception of this ratio, all systolic time intervals were corrected for heart rate utilizing published regression equations. [10] All data were analyzed by the Department of Biostatistics, Wayne State University, using the paired t test for small samples.

Results

The individual dates for the five normal men are enumerated in **Table 1.** In every case the left ventricular ejection time corrected for rate (LVETI) *increased* by five to 10 minutes after the administration of glucagon. This was true also for the

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TABLE I

INDIVIDUAL SYSTOLIC TIME INTERVALS AS INFLUENCED BY GLUCAGON 45 mcg/K, ADMINISTERED INTRAVENOUSLY OVER 1 MINUTE

Subject	Time Min	Hr	LVET (msec)	LEVTI*	LVET	QS$_2$ (msec)	QS$_2$I*	QS$_2$	PEP (msec)	PEPI*	PEP	S$_1$S$_2$ (msec)	ICT (msec)	PEP LVET %
RM	0	73	281	405	-8	391	544	-2	110	139	8	330	49	39
	5	93	266	424	11	366	561	15	100	137	6	311	45	35
	10	83	277	418	5	380	554	8	103	136	5	322	45	37
	15	72	283	405	-8	382	533	-13	99	128	-3	327	44	35
	20	81	270	408	-5	366	536	-10	96	128	-3	312	42	36
MTJ	0	75	290	418	5	387	545	-1	97	127	-4	331	41	33
	5	77	282	413	0	397	559	13	115	146	15	338	56	27
	10	75	297	424	11	400	448	12	103	133	2	340	43	35
	15	74	292	418	5	398	553	7	106	136	5	340	48	36
	20	74	290	416	3	395	550	4	105	135	4	336	46	36
JH	0	71	298	419	6	392	541	-5	94	122	-9	330	32	32
	5	77	296	427	14	388	550	4	92	123	-8	328	32	31
	10	79	296	430	17	390	556	10	94	126	-5	328	32	32
	15	73	302	426	13	396	549	3	94	123	-8	335	33	31
	20	73	295	419	6	392	545	-1	97	126	-5	334	39	33
VG	0	63	295	402	-11	390	522	-24	95	120	-11	331	34	32
	5	66	295	407	-6	391	530	-16	96	122	-19	331	35	33
	10	65	296	407	-6	401	538	-8	105	131	0	337	30	36
	15	64	289	398	-15	400	534	-12	111	137	6	344	55	38
	20	63	290	397	-16	400	532	-14	110	135	4	343	52	38
HG	0	66	297	409	4	404	543	-3	107	133	2	348	56	36
	5	73	290	414	-1	388	541	-5	98	127	-4	337	46	34
	10	67	296	410	3	394	535	-6	98	125	-6	343	48	33
	15	70	299	418	-5	400	547	1	101	129	-2	348	50	34
	20	70	288	407	6	387	534	-6	99	127	-4	338	49	34

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* = rate corrected interval (Index)
= deviation from predicted values as determined by published regression equations for rate correction
ICT = isovolumic contraction time

rate corrected PEP (PEPI) in three of five cases. The latter was not statistically significant at any time following glucagon, whereas the LVETI was significantly greater ($p<0.05$) at 10 minutes and QS$_2$I ($p<0.05$) at five minutes **(Table II).**

Discussion

It is generally recognized that digitalis and catecholamines shorten the PEP, QS$_2$ and LVET.[11-16] This is true even in the presence of failure,[15] and in ischemic states.[17] In the present study, however, these rate corrected indices *increased* in response to glucagon and in the case of the QS$_2$I and LVETI to a significant degree. Moreover, the anticipated reduction of the PEP/LVET which usually accurately reflects changes in myocardial contractility fell at five minutes following a bolus of glucagon to a statistically insignificant degree in marked contradistinction to epinephrine which produced

TABLE II
AVERAGE CHANGE IN RATE CORRECTED SYSTOLIC TIME INTERVALS FOLLOWING INTRAVENOUS GLUCAGON, 45 mcg/K

PARAMETER	STATISTICS	TIME (MINUTES)				
		0	5	10	15	20
QS_2I	$\bar{x}$	539.00	548.20	548.20	543.20	539.40
	$S\bar{d}$		3.25	4.42	4.01	3.78
	t		2.83*	2.08	1.05	0.11
	DF		4	4	4	4
PEPI	$\bar{x}$	128.20	131.00	131.00	130.60	130.20
	$S\bar{d}$		4.28	2.82	4.90	3.70
	t		0.65	0.99	0.49	0.43
	DF		4	4	4	4
LVETI	$\bar{x}$	410.60	417.00	417.80	413.00	409.40
	$S\bar{d}$		3.84	2.15	2.42	1.32
	t		1.67	3.34*	0.99	0.91
	DF		4	4	4	4
PEP/LVET	x	34.40	32.00	34.60	34.80	35.40
	Sd		1.21	1.28	1.81	1.64
	t		1.99	0.16	0.22	0.61
	DF		4	4	4	4

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* $p < 0.05$

striking decreases in this ratio.[16]

Fluxes in LVET generally reflect directionally similar changes in stroke volume.[18-19] This suggests that the positive inotropic effects of glucagon in our group of normal men may have been overshadowed by increases in stroke volume resulting from an increase in systemic venous return. This may be reflected by an increment in cardiopulmonary (central) blood volume[20] as suggested by patients studied in our laboratory **(Table III).**[17] However, such data can be extrapolated to normals only with some skepticism.

It is more difficult to explain the failure of the PEPI to shorten as is usually observed in response to positive inotropic interventions as well as to increases in stroke volume (Frank-Starling effect).[21] A possible explanation may involve a glucagon induced reduction of left ventricular filling pressure (LVEDP) with or without an increment in aortic diastolic pressure (ADP) prolonging the PEP,[22] changes in stroke volume nonwithstanding. Parmley's group has shown, however, that neither variable is effected much by glucagon (i. e. LVEDP or ADP).[8]

A study just published by Byrne, Piggot and Spodick[23] shows a response to glucagon of systolic time intervals very similar to that reported for normals herein. The only difference in the two studies was their rather minor decrease in PEP. This variable was not corrected for rate in their study, however. The average response of the PEP/LVET ratio in their study was similar to ours correlating with increments in inotropism, stroke volume, and especially ejection fraction,[24] but not to the degree seen with catecholamines.

Systolic time intervals result from the interaction of a number of factors including pre-load and after-load as well as by fluxes in myocardial contractility and rate. The former may have overshadowed the positive inotropic effects of glucagon. Presumably, increased myocardial contractility is instrumental in the production of the hemodynamic effects reported for this drug.[8] The glucagon induced hemodynamic changes observed herein, however, occur without the usual hallmarks of inotropism as reflected by systolic time intervals in the manner reported for epinephrine and digitalis.[21]

TABLE III
THE CHANGE IN CARDIOPULMONARY BLOOD VOLUME 6-10 MINUTES AFTER A ONE MINUTE INJECTION OF GLUCAGON AT 45 mcg/K*

Subject	T Sec	AT Sec	CT Sec	MTT Sec	C.O. L/Min.	C.O. cc/Sec	CPV CC	BSA	CPVI_2 cc/M	
SK	$\bar{a}$	21.90	11.06	7.01	25.95	2.11	35.16	912.40	1.51	604.20
	$\bar{p}$	16.60	10.80	7.01	20.39	2.70	45.00	917.60	1.51	607.70
BN	$\bar{a}$	5.40	5.50	4.17	6.75	1.88	31.33	210.85	0.80	263.60
	$\bar{p}$	5.50	6.00	4.17	7.33	2.47	41.20	302.00	0.80	377.50
GW	$\bar{a}$	13.80	12.25	7.01	19.04	2.40	40.00	761.60	1.55	491.40
	$\bar{p}$	12.50	12.25	7.01	17.74	2.40	40.00	209.60	1.55	457.80
EVK	$\bar{a}$	19.60	10.00	7.01	22.69	3.14	52.33	118.70	1.91	621.50
	$\bar{p}$	18.80	10.60	7.01	22.39	3.56	59.30	1328.00	1.91	695.30
HL	$\bar{a}$	8.70	9.80	7.01	11.40	5.05	84.20	959.90	1.79	536.20
	$\bar{p}$	9.40	9.80	7.01	12.19	5.42	90.30	1100.7	1.79	614.90
$\bar{x}$	$\bar{a}$									503.40
$\bar{x}$	$\bar{a}$*									550.60

* t = 1.750, p 0.05
T = Time coordinate of center of gravity of Dye Curve
AT = Time from injection to appearance
CT = Correction for time delay due to sampling system
MTT = Mean transit time
CPV = Cardiopulmonary volume
CPVI = Cardiopulmonary volume index

* For editors use in support of reference 17

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DRUG DETECTION/Continued

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To many, the drug fight seems hopeless. This feeling was reinforced by news commentators who recently reported on statements made by John Ingersoll, the nation's narcotic chief, to Congressmen regarding the inability to make thorough searches of each of the 210 million people entering our country by car, plane or ship each year. Ingersoll was quoted as saying, "I guess we are going to have to resign ourselves to the fact that we are going to have to live with a drug problem in this country and we are going to have to cope with it the best we can."

Although the drug problem will exist as long as there is a demand for drugs, the Michigan Department of Public Health Laboratories will continue to play an essential and responsible role in the effort to control this important health problem in Michigan.

ACUPUNCTURE/Continued

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Perinatal tips

By Paul M. Zavell, MD
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The following case from the files of the Wayne County Medical Society Perinatal Mortality Study Committee is presented as an aid in continuing education.

Maternal

Little is known of this black mother. She came in labor into the emergency room of a hospital and delivered there a 1500 gm black infant. It was learned that the mother had been sniffing heroin throughout her pregnancy and that her last dose was approximately 18 hours prior to delivery of her son. There is no known history of prenatal care. The mother was at approximately 32 weeks gestation.

Fetal

This small infant had marked respiratory distress at the time of delivery with retractions and persistent cyanosis despite resuscitation efforts.

He was taken quickly to the nursery and placed in an incubator. There physical exam revealed a respiratory rate of 68/minute with substernal retractions but lungs were aerated well and clear of rales. Heart rate was slightly elevated at 160/minute. Femoral pulses were palpable. He was alert, active and all other systems seemed to be normal. There were no abnormal CNS signs or symptoms. With the use of 0_2 in the incubator he did well, the respiratory distress gradually clearing. There was no feeding difficulty noted.

However, at about 48 hours of age some intermittent twitching and hypertonic movement of the distal extremities were noted.

He was started on Paregoric by mouth, six drops q6h. This was maintained until the seventh day at which time dosage was gradually reduced until discontinued on the 26th day of life without incident.

At about this time he was noted to have both a decrease in his appetite and sudden onset of increased respirations with some substernal retractions.

Physical exam revealed rales heard in both lung fields but primarily on the right. A chest x-ray taken at this time revealed an infiltrate in the right upper middle lobe (and possibly some in the left lower lobe).

Complicating all this was the fact that during the prior several weeks his hemoglobin had gradually dropped from 10.2 gm to below 9.0 gm.

The infant had tracheal aspiration cultures done revealing Klebsiella sensitive to Kanamycin. He was then placed on Kanamycin 15 mgm q12h IM and Ampicillin started 24 hours earlier was stopped. Also he was started on Fer-in-Sol 0.6 cc daily. Repeat chest x-rays showed gradual, almost complete resolution of the right lung infiltrate with complete clearing of the left. His hemoglobin gradually rose to 9.2 gm with reticulocyte count of 6.7.

During his hospital stay appropriate proceedings were instituted through Social Service so that he was made a ward of the court. On his 54th day of life his weight was now 2880 gm and he was discharged into appropriate care at a foster home.

Final diagnoses: Premature living black male infant

(a) Intrauterine heroin addiction, treated

(b) Iron deficiency anemia, treated

(c) Right upper lobe pneumonia, treated

Perinatal Committee Comments

1. Despite lack of prenatal care and knowledge about her pregnancy it was possible to learn the mother had been sniffing heroin. This simplified the care of the infant somewhat and helped the institution of appropriate care earlier than might have been so otherwise. The hospital medical staff deserves a "pat on the back" for this.
2. Other possible causes for this twitching could be hypocalcemia, hypoglycemia, hypomagnesemia and CNS injury.
3. Treatment of the anemia by oral iron was correct. Use of whole blood here would have been totally unwarranted.
4. Involving the Social Services Department and using the courts to place such a child in a foste home appears fully correct and justified here. Doing nothing could easily lead to a child wh soon is an addict or one placed in a child abus situation.

Doctor Zavell is chairman, Neo-Natal and Hospital Care Commitee, Michigan Chapter, A.A.P., and chairman, Perinatal Mortality Study Committee, Wayne County Medical Society.

The Michigan State Medical Society salutes the Michigan Department of Public Health, marking its 100th year in 1973. The accompanying article describes the Department's own plans for celebration. The following series of articles comprise a small physicians' handbook of information on current public health issues.

Michigan's Department of Public Health marks its 100th year

On July 1 of this year, the Michigan Department of Public Health will observe its 100th birthday. Like the birthdays of most centenarians, it will be observed quietly and without a lot of fanfare.

Reaching the 100 year mark is an accomplishment, of sorts; it testifies to endurance and survival at least. But it is not automatically an occasion for self congratulations. It can be instead an occasion for reflection and for a renewed commitment to the future. As Satchel Paige has said, "Don't look back, something might be gaining on you."

In keeping with that sentiment, the department with the support of Governor Milliken has chosen to observe its Centennial year chiefly by looking ahead toward better health care for Michigan people in the decades ahead. That decision was reached with the encouragement and support of a distinguished group of citizens which has since been appointed as the official Public Health Centennial Advisory Committee. To help achieve the goal, plans are being made for three coordinated conferences on Public Responsibility for Health Care in the '70's.

In addition, the MDPH will hold a luncheon May 18 at the Olds Plaza Hotel, Lansing in conjunction with the annual meeting of the Michigan Public Health Association. A number of Centennial Awards will be made to persons who have made outstanding contributions in the field of public health.

Two conferences are tentatively scheduled for late September. A Professional Conference will involve some 75 selected representatives of professional **providers** of health care; a Citizens Conference will involve some 75 selected representatives of **consumers** of health care.

Each group, meeting separately, will devote its efforts to consideration of priority health problems, possible alternative solutions, and recommendations for action which can be initiated by the State in one form or another. These recommendations will be made directly to the Governor's Public Health Centennial Advisory Committee which will review, consolidate, and distill them as the basis for a Governor's Conference on Health Care to be held in Lansing probably in December.

Participants in the Governor's Conference will, then, be able to focus more sharply on specific issues and specific action. Like the two earlier Conferences, the Governor's Conference is planned as a rolled-up-sleeve, working session designed to produce clear-cut proposals which are feasible and practicable and which will demonstrably effect better health care for well defined groups of Michigan citizens.

(This symbol is being used by the Michigan Department of Public Health in its centennial observance.)

If as expected such proposals do emerge from these conferences; if they are translated into legislative action and better state agency, inter-agency and institutional programming then the centennial observance will have been a meaningful and justified activity on the part of the State and its citizens.

Digest of recommended guidelines for facilities performing pregnancy terminations

Released by the
Michigan Department of Public Health
February 23, 1973

Because of its legal and professional responsibilities, as well as concern for the health, welfare and safety of the citizens of Michigan, the

Michigan Department of Public Health has released recommended guidelines for facilities performing pregnancy terminations while recognizing that they have no legal validity at this time. They were published and released on Feb. 23, 1973, after the Michigan attorney general's decision that the Federal Supreme Court determination on the subject of abortions had invalidated the Michigan law.

The recommended guidelines were originaly produced by an ad hoc advisory committee which included representation from 10 professional and health organizations, including the Michigan State Medical Society, as well as some concerned citizens. The guidelines, with appropriate regulatory rules, were prepared for use in the event the referendum which would have liberalized the Michigan abortion law had passed in the November election.

Following the Supreme Court decision and the Attorney General's ruling, the present recommended guidelines were adapted from the earlier ones and issued in revised form. They removed all reference to licensure of freestanding facilities or other regulatory control by the state during the first trimester of pregnancy to be consistent with the Supreme Court decision. They specify minimal space, equipment, services, including competent counselling, laboratory procedures and a post procedure observation period of at least three hours for all procedures performed on an ambulatory basis.

The guidelines contain various pertinent definitions. They recommend that all termination procedures undertaken beyond the first trimester of pregnancy be done only in hospitals, that all procedures undertaken in hospitals and physician selection be subject to the same types of medical staff policies and procedures relating to physician qualifications and the granting of privileges as obtained for other types of medical staff assignments.

Delineated are the personnel needed, including registered nurses with special background in obstetrics-gynecology or surgery to supervise and provide the nursing care aspects of the program; licensed practical nurses who have had special instruction, and non-professional aides given special training for non-professional assignments in the conduct of the work. Counselling services through physicians, qualified nurses, social workers, or others specially trained and qualified are recommended; also liaison with community counsellors, family planning and the health and social agencies to assure appropriate and adequate post procedure care as well as appropriate contraceptive instruction.

The guidelines particularly stress such legal safeguards as the avoidance of any coersion of a patient to undergo a termination or sterilization procedure against her will, informed written consent of the patient, and avoidance of requirement that any staff physician, nurse or other employee participate in any phase of a termination procedure against his will. They further recommend that complete and adequate medical record information be procured and maintained, including documentation by medical history, positive proof of pregnancy by an accepted pregnancy test as well as the physician's recorded physical findings; the type of procedure used; the type of recovery response during the post procedural period; condition of patient on discharge, and detail of instructions given for post procedural observation and any indicated subsequent care. Provision for consultation and a recorded consultant's note are stressed in the event of any medical condition which might contraindicate the procedure. Also emphasized was written agreement with a nearby hospital for the immediate admission of patients with complications encountered in freestanding clinics.

The guidelines recommend that no general anesthetic be used in the performance of a termination procedure outside of a hospital. In addition to minimal routine laboratory blood and urine testing as well as any other special testing indicated by the patient's history or physical findings, Rh testing is recommended including the administration of Rh immune globulin to all Rh negative patients within 72 hours of the termination when appropriate to the patient's future child bearing potential. V.D., sickle cell and Pap smears where appropriate are recommended. The guidelines stress that if the patient refuses immune globulin therapy when indicated and recommended by the physician, this fact should be noted in the clinical record as well as documented and supported by the patient's signature on an appropriate release form to protect the physician and facility from future liability involving subsequent pregnancy problems.

Recommended minimum space for reception, examination, procedure and recovery areas is detailed as well as minimum necessary equipment, supplies, drugs, medications and solutions essential as safety measures against untoward events which might be encountered.

The guidelines stress that patient safety and welfare be of paramount concern at all times, that reception, interviewing, examination and subsequent care be conducted in a considerate and understanding atmosphere which protects the dignity, privacy and emotional concerns of the patient.

Various other details pertinent to the optimum reception, handling and subsequent care are contained in the document.

Copies of the recommended guidelines are available on request to the Director, Michigan Department of Public Health, 3500 North Logan, Lansing, Michigan, 48914, 517-373-1320.

Health screening for Medicaid children

In the January issue of *Michigan Medicine* MSMS urged component societies to work jointly with county health departments in planning health screening for Medicaid children. A similar appeal was made by the American Academy of Pediatrics to its members in the December Bulletin of Pediatric Practice. It seems that a brief description of this program is in order and would hopefully encourage physician participation in two critical phases of the program — diagnosis and treatment.

In 1967 the federal Social Security Act was amended to require a new Medicaid service called EPSDT—Early and Periodic Screening, Diagnosis and Treatment—under which children up to age 21 are given medical and dental screening, diagnosis and treatment on a periodic basis. There are at least 436,000 children in Michigan who are eligible for these services which Medicaid never before provided to them in Michigan—general health exams and dental care. Many of these children have never seen a doctor except through an emergency room or outpatient clinic.

The possible impact of this program on the health of indigent children should be readily apparent. The United States Department of Health, Education and Welfare has issued regulations and guidelines setting out the minimal content of the EPSDT program. There are three phases to EPSDT — screening for common physical and mental defects, diagnosis and treatment (including dental care, eyeglasses and hearing aids). The screening which is to be arranged through the county health departments will include urinalysis, blood hematocrit, vision and hearing, sickle cell testing, blood lead level if indicated, T.B. tests, GC cultures and immunizations, in addition to a physical examination. The state has directed the counties to have physical exams performed by allied health professionals. It is possible and preferable that county departments arrange for physician consultation in the screening clinics.

Any child who "fails the screening" is to be referred to a physician for diagnosis and treatment. Clearly this follow up is the *critical* part of the program. While there have been several pilot screening programs, the key problem has always been getting screened children to sources of follow up care and the success of this program depends on how well that is accomplished. The Michian Welfare Rights Organization, whose members are parents of children eligible for this program, has worked since last April to see this program finally begun. Because of past difficulty in getting care through Medicaid, MWRO is seriously concerned about follow up and urgently seeks fullscale participation by physicians in this program.

The screening is scheduled to begin in some counties in April (Wayne, Oakland, Ingham, Mason, Saginaw, Kent, Newaygo, Oceana, Lake, Manistee, Mecosta and most of the Upper Peninsula) and in remaining counties in May or June. In order to participate, a physician must be an enrolled Medicaid provider. MWRO urges physicians to fully support EPSDT and to do this by contacting their county health departments which make follow up appointments, to inform the department that they will take referrals for diagnosis and treatment. Furthermore, physicians are encouraged to participate in the planning and reviewing of the actual screening process in their county to see that it is as effective as possible in detecting possible ailments.

Anyone having further questions or interest in the program may call Sally Staebler of the Michigan Legal Services Assistance Program, Detroit (313-577-4822) or call Stuart Paterson, Deputy Director, Medical and Management Information Systems, Department of Social Services, Lansing (517-373-7797).

Physicians must cooperate in child abuse cases

By Eileen M. Courter

Special Affairs Coordinator

Department of Social Services

The number of reported child abuse and neglect cases in Michigan is growing, and the help of physicians and other medical personnel is needed to tackle the problem.

That's the gist of information from the Children's Protective Services Section of the Michigan Department of Social Services, which last year handled more than 16,000 abuse and neglect reports. Social Services officials believe this figure represents only a small percentage of such cases.

The cooperation of physicians is vital to our efforts," says Henry Hofstra, who heads up the Social Services protective services section. Hofstra reminds doctors that Michigan's child abuse law not only requires physicians to report suspected cases of child abuse, but also provides immunity from criminal liability.

The law states that "Any licensed physician who provides medical treatment or makes a medical examination of any child under 17 years of age who has physical injuries which were, or may have been, intentionally inflicted upon him by any person responsible for his care . . . shall immediately cause a report to be made as required by this act. When the attending or examining physician . . . is a member of a hospital . . . staff he shall notify the person in charge thereof of his finding and the person in charge shall cause the report to be made.

Social Services officials point out that the law provides for detaining the child when necessary.

"If the child has been admitted to a hospital or brought to a hospital for outpatient services and the attending physician determines that the release of the child would endanger the child's health or welfare, he shall so report to the person in charge. The person in charge may detain the child until the next regular business day of the probate court, at which time the probate court shall order the child detained in the hospital or in some other suitable place pending a preliminary hearing . . . or order the child released to the parent, guardian or custodian."

The law also provides immunity for "any person acting in good faith who makes a report or in good faith assists in any other requirement of this act including taking a child to an appropriate medical facility or resource for a physical examination."

Finally, "neither the physician-patient privilege nor the privilege between spouses shall prevail in any action, civil or criminal, which is or may have been brought because of any report made pursuant to the provisions of this act."

Protective Services workers say that they often face criticism from physicians who report suspected abuse and later find the child is still at home and nothing seems to have been done.

Hofstra cautions that if a youngster is not removed from his home, this doesn't mean nothing happened.

"We want to work with the parents, not to punish them, but to help them cope with the problems which led to the abuse. Above all, we want to keep the child in his own home with his own family whenever possible."

Copies of the child abuse law, reporting forms and more information are available from County Departments of Social Services.

New policies for TB screening

Mass screening of the general population with Mobile X-ray equipment for tuberculosis is no longer recommended by the American College of Radiology.

A new policy on the chest X-ray as a screening procedure for cardio-pulmonary disease has been adopted by the American College of Radiology, the American College of Chest Physicians and the Department of Health, Education and Welfare.

The Michigan TB and Respiratory Disease Association through its Board of Trustees supported the U.S. Public Health Services recommendation in December of 1972.

In late January of 1973 the MSMS Council also reported this recommendation to discontinue the routine chest X-ray as screening method for cardio-pulmonary diseases.

The formal report from the American College of Radiology Commission on Public Health follows:

The chest X-ray screening procedure covered by this statement may be defined as surveys of the general population using mobile or portable X-ray units. In view of the undesirability of using radiation without clear evidence of significant benefit the Committee on Diseases of the Chest of the American College of Radiology, the American College of Chest Physicians, and the U.S. Public Health Service support a Public Health Program for the detection of cardio-pulmonary disease based on the following considerations.

In the United States today, the public health problem of tuberculosis is concentrated in the older age groups of the population. These individuals are also at high risk for other chronic pulmonary disease and lung cancer. Reported tuberculosis data for 1969 indicate those members of the population who are 45 years or older produced 54 percent of all new active cases of tuberculosis and 87 percent of all deaths from tuberculosis. It is in this older age group that 10 to 40 percent of the population are found to have a positive tuberculin test.

The following recommendations are pertinent:

1. Community chest X-ray surveys among the general population are not productive as a screening procedure for the detection of tuberculosis and should not be done. In a high tuberculosis incidence area where fixed X-ray facilities are limited or not available, it may be necessary to screen selected groups of the population by X-ray in conjunction with the tuberculin skin test. In such circumstances, full follow-up treatment facilities must be available as an essential component of the community tuberculosis

control program. Tuberculin skin tests should be performed for those under age 21 in lieu of a chest X-ray examination, even if periodic examinations are required as a food handler or school employee. Those jurisdictions requiring this type of examination should reevaluate this procedure.

The primary screening of grade and high school children for tuberculosis should not be by X-ray examination. The chest X-ray examination would thus be restricted to the positive reactors to the tuberculin test in the younger age groups. In low prevalence groups, consideration should also be given to the tuberculin skin test as the initial screening examination for case findings. X-ray examination should be restricted to the positive reactors.

2. Community chest X-ray surveys among the general population for detection of other pulmonary disease or heart disease have not proven sufficiently rewarding and should not be done.
3. When radiologic screening of selected groups of the general population may be productive, the full size of film is recommended. The use of the photofluorographic unit as a screening device is justified only under the following conditions:
    a. A definitive interpretation must be made by qualified physicians such as certified radiologist or other physicians with demonstrated competence in the interpretation of the radiographs.
    b. The radiographs and the reports should be made available to the private physicians, public health and hospital agencies, upon request, for a period of at least five years.
    c. The equipment used must meet the requirements of the NCRP Report No. 33. In addition, a photofluorographic unit which gives an exposure of over 200 mR should not be used. Units employing the f 1.5 lens system will fail to meet this requirement and should be replaced with the faster mirror-optic refractive lens system.
4. While community chest X-ray surveys among the general population are not recommended, X-ray facilities for individuals should be available. These may be located in a public health department, private office, or health center.

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

MONTHLY SURVEILLANCE REPORT

CASES OF CERTAIN DISEASES
REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH
For the four-week period ending March 30, 1973

	1973 This 4-Week Period	1972 Same 4-Week Period	1973 Total To Above Date	1972 Total Same Date	Total Cases for 1972
Rubella	268	281	535	583	1,460
Congenital Rubella Syndrome	0	0	1	0	1
Measles	734	312	1,239	710	2,353
Whooping Cough	3	9	25	35	116
Diphtheria	0	0	0	0	1
Mumps	550	475	1,811	1,301	3,729
Scarlet Fever & Strep Sore Throat	2,434	1,426	7,081	4,286	13,304
Tetanus	0	0	0	0	2
Poliomyelitis (paralytic)	0	0	0	0	1*
Hepatitis	306	393	999	1,253	4,322
Salmonellosis (other than S. typhi)	52	56	152	173	781
Typhoid Fever (S. typhi)	2	0	3	1	7
Shigellosis	32	33	129	135	574
Aseptic Meningitis	8	11	30	20	266
Encephalitis	15	3	34	20	108
Meningococcic Meningitis	4	6	11	15	55
H. Influenza Meningitis	12	9	26	20	81
Tuberculosis	124	168	275	412	1,609
Syphilis	367	403	1,142	1,302	4,815
Gonorrhea	2,251	1,777	7,216	5,399	24,728

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, MD, Director
Michigan Department of Public Health

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* corrected total

Everybody experiences psychic tension.

Most people can handle this tension.

Some people develop excessive psychic tension and need your counseling,

and a few may need counseling
and the psychotropic action of Valium® (diazepam).

Before deciding to make Valium
iazepam) part of your treatment
lan, check on whether or not the
atient is presently taking drugs
nd, if so, what his response has
een. Along with the medical and
ocial history, this information can
elp you determine initial dosage,
e possibility of side effects and
e ultimate prospects of success
failure.

While Valium can be a most
elpful adjunct to your counseling,
should be prescribed only as long
excessive psychic tension per-
sts and should be discontinued
hen you decide it has accom-
ished its therapeutic task. In
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e followed, Valium is well
lerated (see Dosage). For con-
enience it is available in 2-mg, 5-mg
d 10-mg tablets.

Drowsiness, fatigue and ataxia
ve been the most commonly re-
rted side effects.

Until response is determined,
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zardous occupations requiring
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driving or operating machinery.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.

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To help you manage excessive psychic tension

msms action

MSMS leaders meet with key legislators

MSMS leaders are continuing their good communications with Republican and Democratic leaders of the Michigan House and Senate through a series of informal dinner meetings at MSMS headquarters. The meetings, unstructured to allow conversations to develop in any area of mutual interest have attracted the following persons:

From left, Robert Jardinico, MD, Saginaw MDPAC board member; Loren D. Anderson, Pontiac, assistant Republican floor leader, and Clifford H. Smart, Walled Lake Republican Leader.

William A. Ryan, left, Democratic Speaker of the House, with Thomas A. Berglund, MD, Kalamazoo, chairman, MSMS Committee on Public Relations, member of the MDPAC executive committee and MSMS Committee on Legal Affairs.

Doctor Berglund, left; Roy L. Spencer, Attica, HR Committee on House Policy, and James S. Farnsworth, Plainwell Republican Caucus Chairman.

Several Democratic representatives gathered for an animated conversation in the MSMS lobby. From left, they are John T. Kelsey, majority caucus chairman; Alma G. Stallworth, majority caucus secretary; Matthew McNeely, speaker pro tempore, and George H. Edwards, assistant majority floor leader.

MATERNAL HEALTH DESK REFERENCE CARD NO. 15

(Sponsored and Prepared by the Committee on Maternal and Perinatal Health,
Michigan State Medical Society)

TOXOPLASMOSIS

ETIOLOGY:

Coccidian parasite—Toxoplasma Gondi

INCIDENCE:

One fourth of U.S. adults have antibodies indicating infection at some time.

One out of every 4,000 newborn babies shows defects due to prenatal infection.

One out of every 1,000 newborn babies is infected but appears normal. An unknown proportion of these may develop neurological problems later in life due to this infection.

TRANSMISSION:

The parasite undergoes reproduction in the intestine of the cat and in other animals. The cat usually acquires the disease from ingested infected mice or raw food scraps. The oocysts excreted by the cat do not become infective for 2-4 days after excretion but are then viable for a year or more in a moist litter box or soil. The cysts gradually become non-viable with drying or can be killed with heat at 56°C (133°F) for 20 minutes, and by freezing at –15°C (5°F) for 24 hours.

In humans, infection occurs through the ingestion of cysts of the organism. Ingested cysts propagate to cause a generalized infection resulting in the formation of cysts in various tissues. Transplacental transmission is thought to occur only at the time of the initial infection of the mother. A mother with a significant antibody titer before pregnancy or one who has had a previous child with congenital Toxoplasmosis may usually be assured that no subsequent child will suffer a congenital infection.

DISEASE:

Acquired Toxoplasmosis can mimic a viral influenza or mononucleosis like syndrome, with fever and cervical adenopathy. In its more severe form it may resemble viral pericarditis or one of the rickettsial spotted fevers. There is some evidence that the disease can be involved in some abortions, stillbirths and premature labors.

In the infant with congenital disease a spectrum of disorders may occur including hyperbilirubinemia, thrombocytopenia, encephalitis, chorioretinitis, seizure disorders, mental retardation and others.

DIAGNOSIS:

The tests that can be performed to assist in diagnosis are:

1. Indirect Fluorescent Antibody Test (IFA)
2. Sabin Feldman Dye Test
3. Indirect Hemagglutination Test (IHA)
4. Complement Fixation Test (CF)
5. Demonstration of organisms in tissue sections
6. Lymph node biopsy
7. Atypical lymphocytes are often demonstrated in the peripheral smear but the screening test for Infectious Mononucleosis is negative.

The most practical test is the IFA. A SINGLE TEST IS NOT DIAGNOSTIC OF DISEASE OR OF NO DISEASE. A RISING TITER DONE

EVERY 2-4 WEEKS WITH AN EIGHT FOLD OR MORE INCREASE IN THE ANTIBODY TITER IS INDICATIVE OF ACTIVE INFECTION.

Titer 1:16 to 1:64	Indicates usually a past exposure or early disease if follow up titer rises.
Titer 1:256 to 1:1024	Possible recent exposure or present involvement if follow up titers rise. 10% of apparently healthy individuals have this level.
Titer 1:1024 & up	Suggests strongly active infection. 1:4000 common in active cases. Less than 5% of apparently healthy individuals have this level.

TREATMENT:

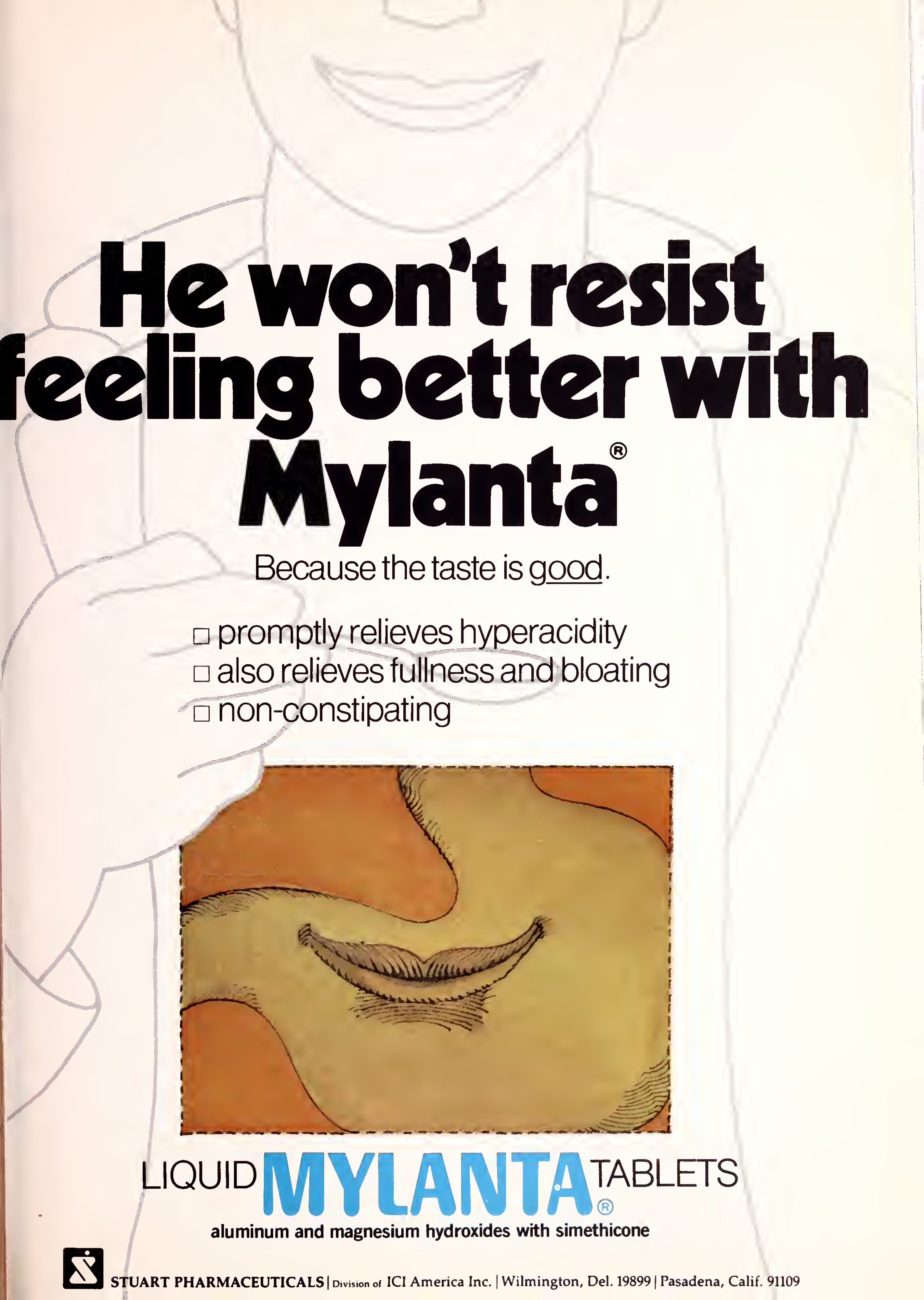
Sulfadiazine and pyrimethamine appear to arrest the progress of the disease but their benefit in preventing sequelae of congenital infection has not been demonstrated. **PYRIMETHAMINE IS A KNOWN TERATOGEN,** (a folic acid antagonist). Because of the possible serious hazards of the fetus, therapy for the mother prenatally is usually not *recommended.*

If sero-conversion or a rise in titer is documented in the first trimester, therapeutic abortion is one alternative that may be considered. The information available, however, shows that only a very small number of infants born of mothers who sero-convert at this time have evidence of the disease.

If treatment is undertaken the patient should be given Leucovorin (5-15 mgm) and 2 cakes of fresh baker's yeast as a source of folinic acid. Leukocyte and platelet counts should be performed twice a week.

PREVENTION: (PARTICULARLY FOR PREGNANT WOMEN)

1. Avoid eating undercooked or inadequately frozen meats. Meat should be heated to at least 133°F (56°C) for twenty minutes or frozen at 5°F (–15°C) for 24 hours.
2. Wash hands thoroughly before eating and after handling raw meats or any contact with cats and other animals or soil.
3. Someone other than pregnant women should empty the litter box daily. Do not feed the cat raw meat scraps, only canned or cooked foods.
4. Cats can be checked by a Veterinarian for disease. Contact with ill animals should be avoided.



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one of the many things you need in an anticholinergic.

Pro-Banthīne is provided in several different dosage forms and combinations which will meet virtually any clinical need. It is just as versatile in filling patient needs, among which are:

"Antiacid" action—Pro-Banthīne® (propantheline bromide) reduces gastric secretory volume and resting total and free acid.

"Sustained" action—Pro-Banthīne P.A.® (propantheline bromide) contains 30 mg. of the drug in the form of sustained-release or timed-release beads; on ingestion about half of the drug is released within an hour and the remainder continuously as earlier increments are metabolized.

High-level anticholinergic activity is maintained all day and all night in most patients with only two tablets every eight hours.

"Analgesic" action—Pro-Banthīne helps to control the acid-spasm-pain complex.

A "diagnostic tool"—Pro-Banthīne may be used parenterally to immobilize the duodenum for more revealing roentgenographic appraisal through hypotonic duodenography.

Pro-Banthīne is considered adjunctive in total peptic ulcer therapy that may include diet, conventional antacids, bed rest, and other supportive measures.

Vigorous anticholinergic action — Pro-Banthīne® Vials, 30 mg., are for intramuscular or intravenous use when prompt and vigorous anticholinergic action is required.

Mild anticholinergic action—Pro-Banthīne® Half Strength, 7.5-mg. tablets, for more exact adjustment of maintenance dosage in mild to moderate gastrointestinal disorders.

Indications: Pro-Banthīne is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution.

Fever and possibly heat stroke may occur due to anhidrosis.

In theory a curare-like action may occur, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthīne.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

Pro-Banthīne P.A.—Each tablet of Pro-Banthīne P.A. (propantheline bromide) contains 30 mg. of the drug in the form of sustained-release or timed-release beads; on ingestion about half of the drug is released within an hour and the remainder continuously as earlier increments are metabolized. Thus the result is even, high-level anticholinergic activity maintained all day and all night in most patients with only two tablets daily. Some patients may require one tablet every eight hours.

The contraindications and precautions applicable to Pro-Banthīne 15 mg. should be observed.

How Supplied: Pro-Banthīne is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

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Perhaps you've seen pages in newspapers and national magazines signed "America's Doctors of Medicine." They're part of this program. It tells the true story of what it takes to become a doctor. The ways American medicine has improved the public's health. And to express the profession's concern about health by providing information which will help every American lead a healthier life.

We're telling this story for you, the American doctor. If we are to continue to represent you effectively, we need your support.

Find out more about what the AMA does for you and the public. Send for the pamphlet, "The AMA and the American Doctor: Sharing a Common Goal." Write: Dept. DW, at the address below.

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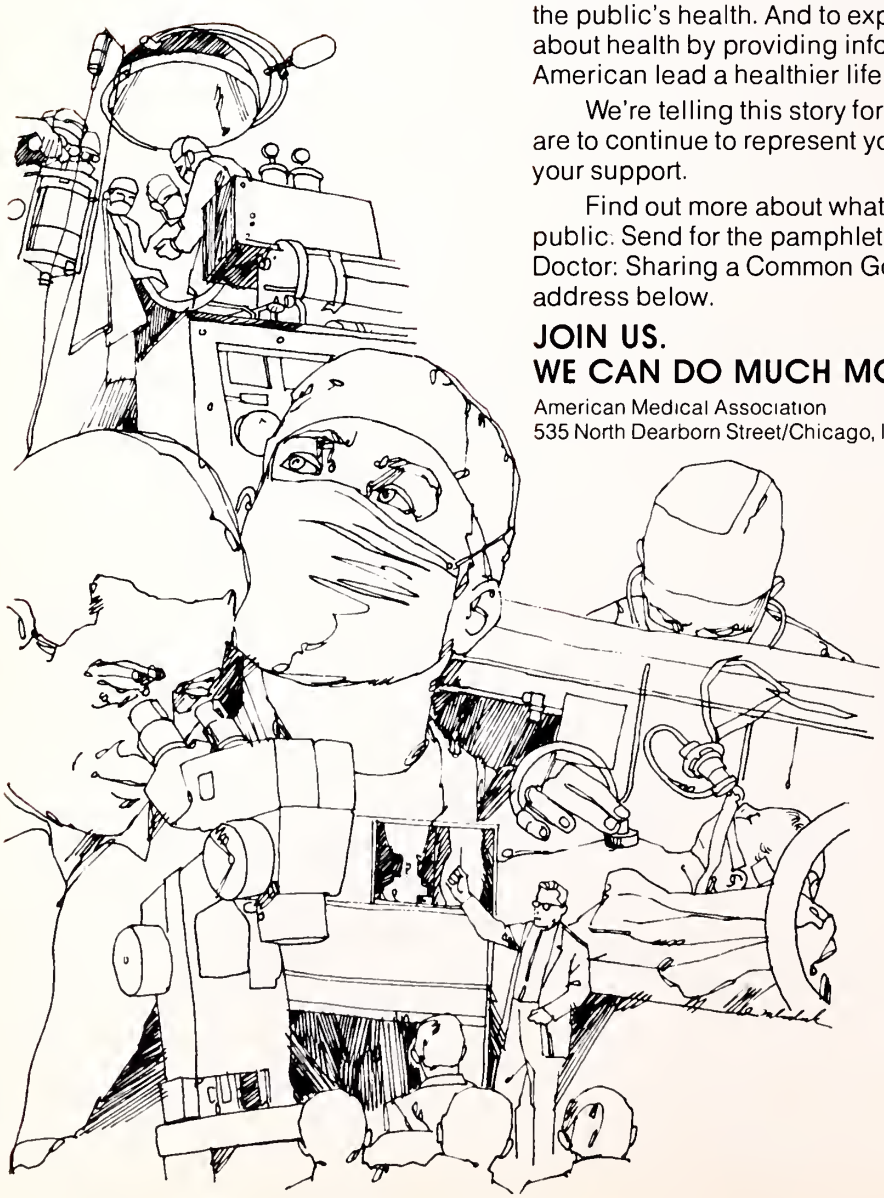

AMA President, C.A. Hoffman, MD comes to Detroit

Leonard M. Pickering, MD, left, receives a plaque from AMA President Charles A. (Carl) Hoffman, MD, for his service in 1972 with the AMA's Volunteer Physicians for Viet Nam program. Doctor Pickering served in November and December in Tam-Ky. He previously served in May-July 1968 in Rach Gia in the AMA project. The presentation was made during the WCMS open house April 8 for AMA President Hoffman, who was in Detroit to address the Economic Club.

MSMS President John J. Coury, MD, third from left, tells AMA President Charles A. (Carl) Hoffman, MD, about some of the Michigan efforts to promote AMA memberships. Left to right at the Hoffman reception are Donald N. Sweeny, Jr., MD, chairman of the MSMS delegation to the AMA; Doctor Hoffman; Doctor Coury, and Robert M. Leitch, MD, chairman of the MSMS Council.

Mrs. Sidney Chapin, left, wife of the Wayne County Medical Society president, chats with Mrs. Hoffman during the open house held at the WCMS headquarters for Doctor Hoffman, the AMA president.

The largest delegation sent by any component society was the group of team physicians and coaches sponsored by the Ottawa County Medical Society. The project was chaired by Donald DeWitt, MD, third from left, chairman of the Ottawa committee on public relations. The eighth annual MSMS conference drew 110 at the Hospitality Inn, Lansing, April 5.

MSMS Sports Conference draws crowd to East Lansing

The growing importance of good training and medical care for high school girl athletes was stressed by Carol Davis, MSU, at the conference. Here she is interviewed by Al Sandner of the *Detroit News.*

Melvin L. Olix, MD, right, Ohio State team doctor, answers questions about his speech on knee injuries. At left is Robert Evans, MD, chairman of the MSMS Committee on the Medical Aspects of Organized Athletics, and center is James S. Feurig, MD, MSU team physician and conference program chairman.

Dear Doctor:

This month's "Bio-Science Reports," on the page opposite, is another service of Bio-Science Laboratories.

From time to time, you'll be seeing different reports in Michigan Medicine dealing with laboratory medicine as it applies to your clinical practice.

Over the past 25 years, physicians such as yourself have found that our laboratory service provides a continuing source of accurate results and helpful literature.

Please use the coupon at the bottom of the "Bio-Science Reports" to request any information about our services, fees, or free starter materials.

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Donald C. Cannon

Donald C. Cannon, M.D., Ph.D.
Director

25 YEARS
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Bio-Science Reports

The Venereal Disease Epidemic:

How To Use The Laboratory

In our newly revised "Laboratory Aid" (see below) devoted to diagnosis and treatment of syphilis and gonorrhea we quote Dr. Sidney Olansky: "Therefore, we have reached the point where the serologic problems associated with syphilis almost always can be resolved with the proper use of two tests: the VDRL slide test and the FTA-ABS test." ("Serodiagnosis of Syphilis" in The Medical Clinics of North America *56*:1145, 1972.) From our broad experience in laboratory services devoted to the diagnosis and follow-up of syphilis we know that the "almost always" part of Dr. Olansky's statement describes those situations which are most troublesome to physicians.

The VDRL test is somewhat insensitive in very early syphilis. Thus the FTA-ABS test, not ordinarily considered a screening procedure, may sometimes be the test of choice in those instances when the physician suspects early syphilis in the face of a "Non-reactive" VDRL test.

When a diagnosis of syphilis has been made, the efficacy of treatment should be checked by *periodic quantitative VDRL tests*—not by the FTA-ABS test, which may remain reactive for life even in cured syphilis.

False positive VDRL tests are usually transient and of low titer. If reactivity persists, the clinician should suspect an underlying "auto-immune" disturbance, perhaps SLE. Although not as frequent, false positive FTA-ABS tests also occur, usually because there is another disease involved; however, final resolution may not be possible until autopsy, if at all. The question of whether or not to start antibiotic therapy becomes strictly a clinical decision.

A recently described modification of the FTA test using CSF is available from our laboratory and may be of help or physicians faced with the possibility of neurosyphilis n older patients with *sero*-negative VDRL and reactive TA-ABS tests. (Brit. J. Ven. Dis. *48*:97, 1972.)

Some Words on Gonorrhea

Unfortunately, a simple inexpensive screening test analogous to the VDRL is not yet available for gonorrhea. Transgrow Collection Kits make the services of our reference laboratory available to any physician seeking "bacteriological" confirmation of GC.

The Complement Fixation test for *N. gonorrhoeae* may be of value in uncovering "hidden" GC in the relatively asymptomatic female and in the Asian variety of gonorrhea.

In Summary

Bio-Science Laboratories offers an exceptionally complete array of tests to aid in the diagnosis of both syphilis and gonorrhea; our new booklet, "Laboratory Aids for the Diagnosis and Treatment of Gonorrhea and Syphilis," is available at no cost or obligation to guide clinicians in the selection of the appropriate tests and in the interpretation of test results.

Pertinent Tests Available at Bio-Science Laboratories

VDRL, qualitative, quantitative, and pre-marital
FTA-ABS
FTA, modified, for cerebrospinal fluid
Darkfield examination (local clients)
Direct FA stain for *T. pallidum*
(for mailed specimens)
Gram stain and/or FA stain for *N. gonorrhoeae*
Complement-fixation Test for antibodies to
N. gonorrhoeae
Routine culture for GC (local clients)
Transgrow Collection Kit for GC cultures
(for mailed specimens)

Bio-Science Laboratories

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Philadelphia Branch:
116 So. Eighteenth St.
Philadelphia, Pa. 19103

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7600 Tyrone Avenue
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Gentlemen: Please send me—

☐ A copy of your booklet on LABORATORY AIDS FOR THE DIAGNOSIS AND TREATMENT OF GONORRHEA AND SYPHILIS.

☐ A STARTER LAB PACK containing a small supply of postage-paid mailing containers and FEE SCHEDULE.

Name

Address

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FREE! Laboratory Aids for the Diagnosis and Treatment of Gonorrhea and Syphilis

Laboratory Aids for the Diagnosis and Treatment of Gonorrhea and Syphilis

This 12-page booklet, written by Drs. Olitzky and Blaker of the staff of Bio-Science Laboratories, contains a clear and graphic summary of the value and limitations of laboratory technics in the assessment of these venereal disease problems. You will find it to be a quick and ready reference to update yourself in this important area of laboratory medicine. Copies are available to physicians and lab personnel without obligation. Simply fill out and mail this coupon.

Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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Frederick B. Andrews, MD, 2765 Flushing Rd., Flint, 48504
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Osvaldo J. Caffa, MD, 20905 Greenfield, Southfield, 48075
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A. C. Chawla, MD, 15041 E. Seven Mile Rd., Detroit,48205
Thomas Ching-Wen Chen, MD, 3237 Belle Ct., Royal Oak, 48072
Allen Chernick, MD, 18510 Meyers, Detroit, 48235
Bok Sung Chung, MD, 540 E. Canfield, WSU school of Medicine, Detroit., 48201
John Wm. Coles, MD, 314 S. Brown St., Mt. Pleasant, 48858
Ralph R. Cook, MD, 111 Kerner Court, Midland, 48640
Robert D. Coye, MD, 540 E. Canfield, Detroit, 48201
Leonard Gordon Dorey, MD, Pontiac Gen. Hosp., 461 W. Huron St., Pontiac, 48053
Dale A. Dykema, MD, 1367 Oriole Ct., SW, Grand Rapids, 49509
Charles D. Fess, MD, 1305 W. Franklin, Jackson, 49203
Larry W. Fitzsimmons, MD, 4528 S. Hagadorn, E. Lansing, 48823
Pedro S. Franco, MD, 405 Northland Med. Bldg., Southfield, 48075
Reed K. Freidinger, MD, 3233 Belle Ct., Royal Oak, 48072
David W. Gelfand, MD, Sinai Hospital, Detroit, 48235
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H. K. Haveliwala, MD, 31465 Harlo, Apt. G, Madison Heights, 48071
Ethelene C. Jones, MD, 3800 Woodward, Detroit, 48201
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Michael R. Linn, MD, Gratiot Comm. Hosp., Alma, 48801
Joseph G. Mach, MD, 3231 Coolidge, Royal Oak, 48072
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Louis R. Mengoli, MD, 1665 W. 12 Mile Rd., Berkley, 48072
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Sukhamoy Paul, MD, 369 Glendale, Highland Park, 48203
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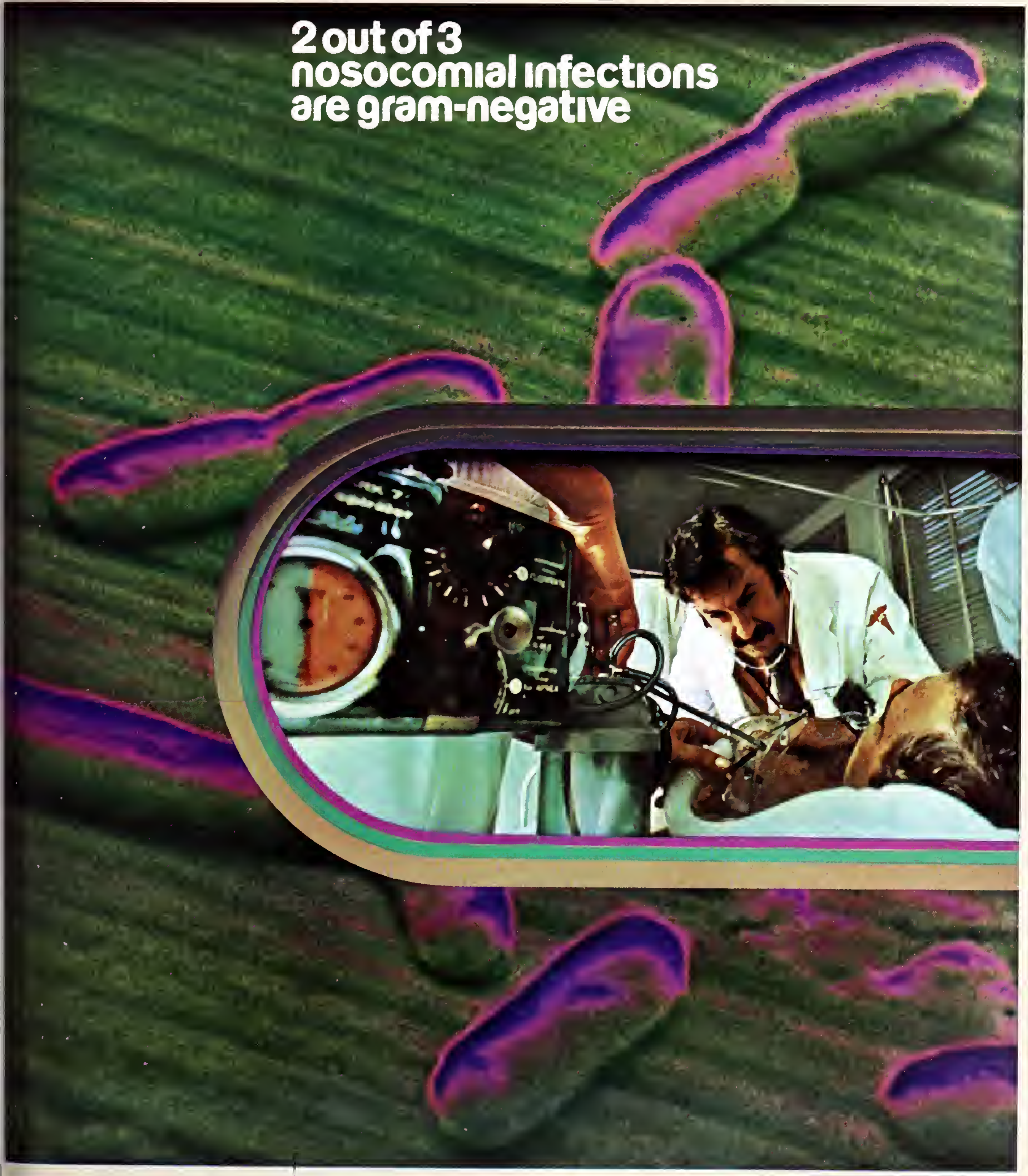
Sumer Verma, MD, Dept. of Psychiatry - Mich. St. Univ., E. Lansing, 48823
Ronald Watson, MD, 3207 Coolidge, Royal Oak, 48072
Waldemar J. Wajszczuk, MD, 6767 W. Outer Dr., Detroit, 48235
J. F. Williamson, MD, 510 Prospect, Alma, 48801
Robert A. Wolf, MD, 690 Mullett St., Detroit, 48226

(Continued on page 379)

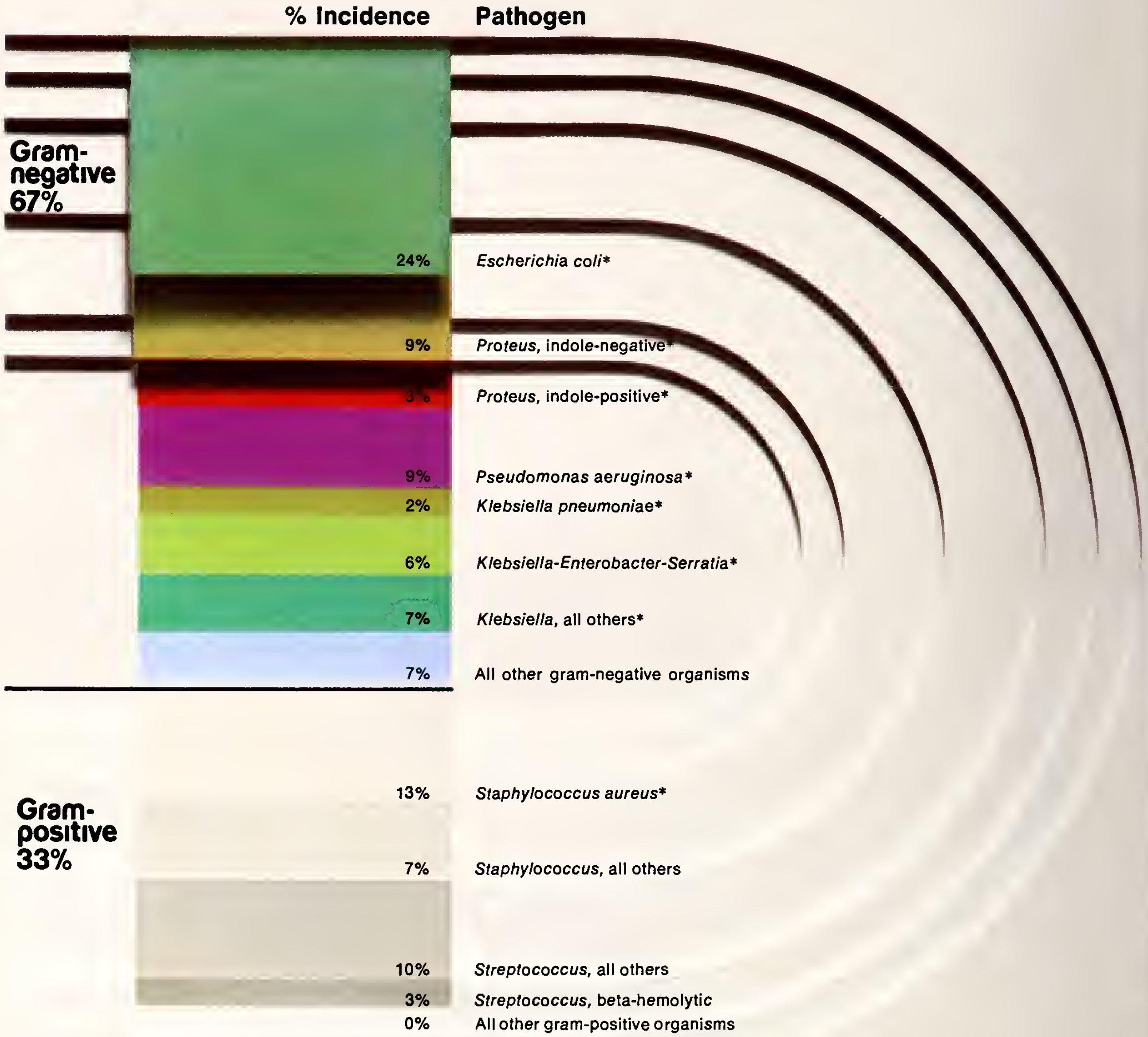
Schering

On all in-patient services...
a major problem


2 out of 3
nosocomial infections
are gram-negative

Gram-negative bacteria magnified 10,000 times—color-tinted

Commonly encountered pathogens on all hospital services



Total pathogans 21,972
Source: Gossalin Audit of Pathology Cultures—1971

*GARAMYCIN Injectable is effective against susceptible strains of the pathogens indicated

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A highly appropriate spectrum for today's problem pathogens

GARAMYCIN Injectable offers a high
robability of effectiveness against susceptible
trains of seven out of seven major gram-
egative pathogens. These are:

Escherichia coli
Proteus, indole-negative
Proteus, indole-positive
Pseudomonas aeruginosa
Klebsiella }
Enterobacter } species
Serratia }

GARAMYCIN Injectable has also been shown
 be effective in serious staphylococcal infec-
ons. It may be considered in those infections
hen penicillins or other less potentially toxic
rugs are contraindicated and bacterial
usceptibility testing and clinical judgment
dicate its use.

serious gram-negative infections
neumonia, urinary tract infections,
epticemia, and wound infections)*
e to susceptible organisms

Start with Garamycin

- **Broad gram-negative spectrum**
Because of its broad gram-negative spectrum and its well-established clinical efficacy, GARAMYCIN Injectable can be considered for initial therapy in suspected as well as documented gram-negative sepsis.

Stay with Garamycin

- **Susceptibility of causative organisms confirmed**
The results of susceptibility tests will, in most cases, demonstrate the causative organisms' sensitivity to GARAMYCIN Injectable. However, the decision to continue therapy with this drug should also be based on the severity of the infection and the important additional concepts contained in the Warning Box.
- **Relatively low incidence of adverse reactions**
Risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.
- **Bacterial resistance has not been a problem**
In the laboratory, resistance has been demonstrated to develop slowly in stepwise fashion. No one-step mutations to high resistance have been reported to date.

On all in-patient services...

Garamycin®

gentamicin sulfate **injectable**

I.M./I.V.

40 mg. per cc.
Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin

WARNING
Patients treated with GARAMYCIN Injectable should be under close clinical observation because of the potential toxicity associated with the use of this drug.

Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment.

Monitoring of renal and eighth nerve function is recommended during therapy of patients with known impairment of renal function. This testing is also recommended in patients with normal renal function at onset of therapy who develop evidence of nitrogen retention (increasing BUN, NPN, creatinine or oliguria). Evidence of ototoxicity requires dosage adjustments or discontinuance of the drug.

In event of overdose or toxic reactions, peritoneal dialysis or hemodialysis will aid in removal of gentamicin from the blood.

Serum concentrations should be monitored when feasible and prolonged concentrations above 12 mcg./ml. should be avoided.

Concurrent use of other neurotoxic and/or nephrotoxic drugs, particularly streptomycin, neomycin, kanamycin, cephaloridine, viomycin, polymyxin B, and polymyxin E (colistin), should be avoided.

The concurrent use of gentamicin with potent diuretics should be avoided, since certain diuretics by themselves may cause ototoxicity. In addition, when administered intravenously, diuretics may cause a rise in gentamicin serum level and potentiate neurotoxicity.

USAGE IN PREGNANCY Safety for use in pregnancy has not been established.

See Clinical Considerations section which follows...

Schering

On all in-patient services... in hospital-acquired gram-negative infections*

Garamycin®

gentamicin sulfate injectable

I.M./I.V.

40 mg. per cc.

Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin

Also available:
GARAMYCIN® Pediatric Injectable, 10 mg. per cc.

GARAMYCIN® Injectable, brand of gentamicin sulfate U.S.P., injection, 40 mg./cc.
Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin
For Parenteral Administration

WARNING
Patients treated with GARAMYCIN Injectable should be under close clinical observation because of the potential toxicity associated with the use of this drug.

Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

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USAGE IN PREGNANCY **Safety for use in pregnancy has not been established.**

INDICATIONS GARAMYCIN Injectable is indicated, with due regard for relative toxicity of antibiotics, in the treatment of serious infections caused by susceptible strains of the following microorganisms:

Pseudomonas aeruginosa, Proteus species (indole-positive and indole-negative), **Escherichia coli** and **Klebsiella-Enterobacter-Serratia** species.

Clinical studies have shown GARAMYCIN Injectable to be effective in septicemia and serious infections of the central nervous system (meningitis), urinary tract, respiratory tract, gastrointestinal tract, skin and soft tissue (including burns).

Bacteriologic tests to determine the causative organisms and their susceptibility to gentamicin should be performed.

Bacterial resistance to gentamicin develops slowly in stepwise fashion; there have been no one-step mutations to high resistance.

In suspected or documented gram-negative sepsis, GARAMYCIN may be considered as initial therapy. The decision to continue therapy with this drug should be based on the results of susceptibility tests, the severity of the infection, and the important additional concepts contained in the Warning Box. In the neonate with suspected sepsis or staphylococcal pneumonia, a penicillin type drug is usually indicated as concomitant antimicrobial therapy.

GARAMYCIN Injectable has been shown to be effective in serious staphylococcal infections. It may be considered in those infections when penicillins or other less potentially toxic drugs are contraindicated and bacterial susceptibility testing and clinical judgment indicate its use.

CONTRAINDICATIONS A history of hypersensitivity to gentamicin is a contraindication to its use.

WARNINGS See Warning Box.

PRECAUTIONS Neuromuscular blockade and respiratory paralysis have been reported in the cat receiving high doses (40 mg./kg.) of gentamicin. The possibility of these phenomena occurring in man should be considered if gentamicin is administered to patients receiving neuromuscular blocking agents such as succinylcholine and tubocurarine.

Treatment with gentamicin may result in overgrowth of nonsusceptible organisms. If this occurs, appropriate therapy is indicated.

ADVERSE REACTIONS

Nephrotoxicity: Adverse renal effects, as demonstrated by rising BUN, NPN, serum creatinine and oliguria, have been reported. They occur more frequently in patients with a history of renal impairment treated with larger than recommended dosage.

Neurotoxicity: Adverse effects on both vestibular and auditory branches of the eighth nerve have been reported in patients on high dosage and/or prolonged therapy. Symptoms include dizziness, vertigo, tinnitus, roaring in the ears and hearing loss.

Numbness, skin tingling, muscle twitching, and convulsions have also been reported.

Note: The risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.

Other reported adverse reactions, possibly related to gentamicin, include increased serum transaminase (SGOT, SGPT), increased serum bilirubin, transient hepatomegaly, decreased serum calcium; splenomegaly, anemia, increased and decreased reticulocyte counts, granulocytopenia, thrombocytopenia, purpura; fever, rash, itching, urticaria, generalized burning, joint pain, laryngeal edema; nausea, vomiting, headache, increased salivation, lethargy and decreased appetite, weight loss, pulmonary fibrosis, hypotension and hypertension.

DOSAGE AND ADMINISTRATION GARAMYCIN Injectable may be given intramuscularly or intravenously.

For Intramuscular Administration:

PATIENTS WITH NORMAL RENAL FUNCTION*

Adults: The recommended dosage for GARAMYCIN Injectable for patients with serious infections and normal renal function is 3 mg./kg./day, administered in three equal doses every 8 hours.

For patients weighing over 60 kg. (132 lb.), the usual dosage is 80 mg. (2 cc.) three times daily. For patients weighing 60 kg. (132 lb.) or less, the usual dose is 60 mg. (1.5 cc.) three times daily.

In patients with life-threatening infections, dosages up to 5 mg./kg./day may be administered in three or four equal doses. This dosage should be reduced to 3 mg./kg./day as soon as clinically indicated.

*In children and infants, the newborn, and patients with impaired renal function, dosage must be adjusted in accordance with instructions set forth in the Package Insert.

For Intravenous Administration:

The intravenous administration of GARAMYCIN Injectable is recommended in those circumstances when the intramuscular route is not feasible (e.g., patients in shock, with hematologic disorders, with severe burns, or with reduced muscle mass).

For intravenous administration, in adults, a single dose of GARAMYCIN Injectable may be diluted in 100 or 200 cc. of sterile normal saline or in a sterile solution of dextrose 5% in water; in infants and children, the volume of diluent should be less. The concentration of gentamicin in solution, in both instances should normally not exceed 1 mg./cc. (0.1%). The solution is infused over a period of 1 to 2 hours.

The recommended dose for intravenous administration is identical to that recommended for intramuscular use.

GARAMYCIN Injectable should not be physically pre-mixed with other drugs, but should be administered separately in accordance with the recommended route of administration and dosage schedule.

HOW SUPPLIED GARAMYCIN Injectable, 40 mg. per cc., 2 cc. multiple-dose vials for parenteral administration.

Also available, GARAMYCIN Pediatric Injectable, 10 mg. per cc., 2 cc. multiple-dose vials for parenteral administration.

APRIL, 1972
AHFS Category 8:12.28

For more complete prescribing details, consult Package Insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.

---

*Due to susceptible organisms

SLR 301

The following are all at: William Beaumont Hospital, 3535 W. 13 Mile Rd., Royal Oak, MI 48072

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Francisco R. Alvarez, MD
Gumersindo A. Alvero, MD
Marc Arnkoff, MD
Miles Steven Auster, MD
Badiollah Badiei, MD
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ALSO AVAILABLE FOR THE TREATMENT OF

impotence

due to androgenic deficiency in the American male.

Android® 5 MUQETS BUCCAL Tabs
Methyltestosterone N.F. - 5 mg.

Android® 10
Methyltestosterone N.F. -10 mg.

Android® 25
Methyltestosterone N.F. -25 mg.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en 3-one.

ACTIONS Methyltestosterone is an oil soluble androgenic hormone.

INDICATIONS In the male· 1 Eunuchoidism and eunuchism 2 Male climacteric symptoms when these are secondary to androgen deficiency 3 Impotence due to androgenic deficiency 4 Postpuberal cryptorchidism with evidence of hypogonadism
Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone These changes appear to be related to dosage of the drug Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

PRECAUTIONS Prolonged dosage of androgen may result in sodium and fluid retention This may present a problem, especially in patients with compromised cardiac reserve or renal disease In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

CONTRAINDICATIONS· Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast Contraindicated in the presence of severe liver damage.

WARNINGS: If priapism or other signs of excessive sexual stimulation develop, discontinue therapy In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development Hypersensitivity and gynecomastia may occur rarely PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastic breast carcinoma. If this occurs, the drug should be discontinued.

ADVERSE REACTIONS: Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastic breast carcinoma This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia

DOSAGE AND ADMINISTRATION Dosage must be stricly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as an average daily dosage guide.

INDICATION	Average Daily Dosage Tablets
In the male:	
Eunuchoidism and eunuchism	10 to 40 mg.
Male climacteric symptoms and impotence due to androgen deficiency	10 to 40 mg.
Postpuberal cryptorchism	30 mg.

HOW SUPPLIED: 5, 10, 25 mg. In bottles of 60, 250.

REFER TO PDR

Write for Literature and Samples

BROWN

THE BROWN PHARMACEUTICAL CO., INC.
2500 West 6th Street, Los Angeles, California 90057

BARRY
STINGING INSECT ANTIGEN

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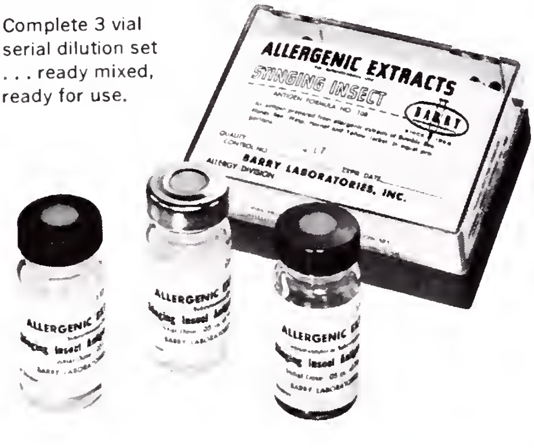

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Doctor Stilwill Asks For MM Articles On Leadership

To the editor:

I note in the *Medigram* of March 8, 1973, (Vol. 72, No.8) that 22 Michigan representatives attended the first AMA National Leadership Conference on February 16-18 in Chicago (for state and county officers and executives). This conference was attended by 758 persons across the country. The conference was keynoted by Doctor Coury.

I further note that the presidents of the component medical societies and MSMS counselors have been invited to a workshop on leadership skills on March 28, 1973, at the MSMS headquarters.

It is my opinion that most of us in the Michigan State Medical Society could improve our leadership skills to "preserve and strengthen the federation of American medicine" as declared by AMA Executive Vice President Ernest B. Howard, M.D. (also as reported in *Medigram,* same issue).

Could not some of the pertinent points and development of leadership skills be brought out in articles in "Michigan Medicine" occasionally? Some leadership conferences can be extremely valuable. Could we not all share in the conference sponsored by the AMA and MSMS via "Michigan Medicine"?

Sincerely yours,

George D. Stilwill, M.D.

Editor's note: Doctor Stilwill's point is well made, and if other MSMS members have suggestions for articles they'd like Michigan Medicine *to carry, we'd like to have them.*

Doctor Hayes Calls For More Flexibility In O.B. Departments

To the Editor:

Physicians, of all others, must know that in medicine there is no room for inflexibility, autocracy, absolutes. Thus, it seems appropriate to ask certain questions concerning obstetric care in Michigan. It seems to be incongruous that the March *Michigan Medicine* starts with a "Long, Hard Look at Michigan O.B. Departments," which deals in absolutes, and closes the issue with an article on U of M midwife ready to begin delivering babies. Somewhere between these extremes must lie a happier solution to obstetric care in Michigan and particularly in rural areas. I would suggest that a longer and harder look be taken of obstetrics.

One gathers from the article on O.B. Bed Utilization that size alone is the major factor in good obstetric care. From a common sense standpoint, big is not always better. The figures quoted do not lend themselves to statistical significance. There is a dilution factor, since there are five times as many hospitals with 500 or less deliveries as hospitals of 2,000 or more. One bad hospital could destroy the image of all in that class. Hence, the spread of maternal deaths in each class is a major factor. In fact, one maternal death either way would alter several size categories.

The only meaningful study would be to analyze the maternal and fetal deaths that were deemed avoidable and determine the exact cause in each case. Such study would more surely improve obstetric care in Michigan. One would wonder about hemorrhage, infection, laboratory errors, quality of personnel, improper drug dosage, age of patient, amount of prenatal care, economic status, physician availability, anaesthesia, alcoholism, fetal position, and more. The size of the O.B. department as a cause per se of poor obstetrics seems to be a subtle attempt to divorce obstetrics from the practice of medicine.

Much has been made of the time and distance factor of the patient from the hospital. But what of the doctor? If he must take an hour round trip to check his mother in labor, how many times can he see her in a busy day? Is this good obstetrics to run at the last minute when his patient is ready to deliver? Too much stress on the rules and too little thought for the doctor, whose needs ought to demand first priority.

A new breed of doctor is rapidly being trained in family practice to meet well, eighty-five percent of the medical needs of the family. Certainly, babies are the foundation of the family, and obstetrics must be an important part of family practice.

Not only is family practice the style of medicine most people want, but it is ideally designed to meet the needs of rural America and the doctor shortage where it exists. But if these doctors are denied the tools of their trade, how can they practice? These facilities should certainly include labor and delivery rooms. In fact, this is a crucial problem which must be solved if doctors are to practice in small town U.S.A.

Rural doctors have unique problems, and each is important. There are no interns or residents — no male orderlies. He puts on his own casts, starts his own IV's, inserts male catheters, helps get heavy patients out of bed. There is subzero weather, calls before the plow comes through, poor side roads. And he is on call 24 hours a day for every emergency. Clearly, such a doctor needs a base of operations close at hand. Time is his most imporant asset.

(Continued on page 387)

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Rural health conference May 24 in East Lansing

Family medicine, health manpower and health education will be the topics when MSMS, the Michigan Health Council and Michigan State University co-sponsor the Michigan Conference on Rural Health May 24 at Kellogg Center, East Lansing.

The keynote address will be delivered by Maurice S. Reizen, MD, director, Michigan Department of Public Health. Other participants will include Donald Smith, MD, Ann Arbor, director, Governor's Office of Health and Medical Affairs, and Russell W. Mawby, PhD, president, W. K. Kellogg Foundation.

Three Michigan health leaders will be inducted into the state's Health Hall of Fame during the day-long meeting, which is scheduled on Education Day of Michigan Week.

The three are Otto K. Engelke, MD, retired head of the Washtenaw County Health Department and former president of MSMS, the Michigan Health Council, Michigan Public Health Association and the Michigan Health Officers Association; Gordon H. Scott, PhD, deceased former dean and vice president for medical affairs at the WSU School of Medicine and prime mover in the development of the Detroit Medical Center, and Philip E. Blackerby, DDS, retired former president of the Kellogg Foundation.

General chairman is Donald R. McCorvie, MD, Williamston, chairman, MSMS Committee on Rural Medical Service.

Community calls on Muskegon MDs

Muskegon physicians have been involved in two community projects lately. In February they were contacted by a local pharmacy which offered to pay the tuition for one year at Muskegon County Community College for a student selected by the MCMS membership. The physicians decided to ask the pharmacy to split the funds between two students, one underprivileged and another who excels.

Muskegon physicians also are being asked to serve as supervisors for a new privately-owned medical facility being developed in Muskegon Heights to serve medically indigent persons. The facility is to have 20 examining rooms and to be staffed by family practice associates and physicians' assistants.

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Mrs. Francis P. Rhoades, Detroit, past president of the Woman's Auxiliary to MSMS, and wife of a past president of MSMS, receives a bouquet of native flowers from Australian Minister for Tourism, Sir Donald Anderson.

ZIP CODE 48823/Continued

Conclusion:

Rural family physicians have many unique needs and problems which cannot be solved by the general guidelines for big city hospitals. There must be more flexibility and understanding if the happy compromise between midwives and ivory tower medicine is to be achieved. Family practice is the best medicine and obstetrics is the basis of family practice.

Sincerely yours, Willard N. Hayes M.D. FAAFP
Graduate U of M 1942

Red carpet was out for MSMS visitors to South Pacific

One hundred sixty five Michigan physicians and their families aboard the recent MSMS travel tour to the South Pacific received an unusually warm welcome as they debarked in Australian and New Zealand airports.

In Sydney, they were met by the U.S. ambassador, the minister for tourism, the director-general of the Department of Civil Aviation and World Airways representatives, who arranged the flights.

At several stops, they were met by television and radio news crews.

The reason for the extraordinary welcome, which came as a surprise to the Michigan visitors, was that they were aboard the first of a series of charter flights arranged by the American-owned World Airways as an experiment upon which the effect of charters on the Australian and New Zealand airline and tourist business could be assessed.

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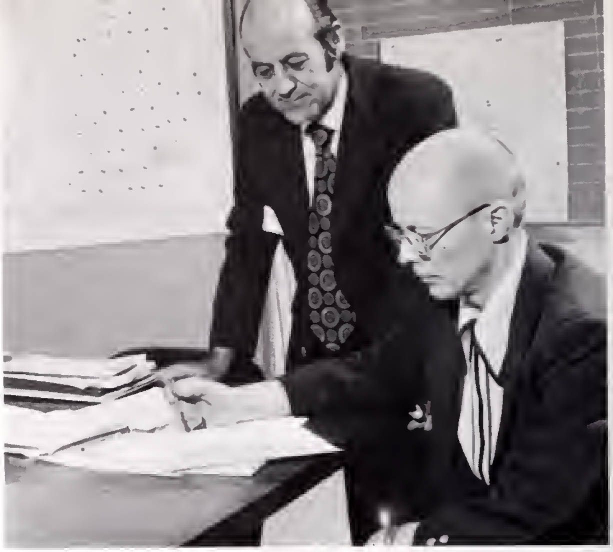
Richard D. Watkins, M.D.
Robert M. Zimmerman, M.D.

MSMS leadership to help determine the direction of PSRO development in Michigan is concentrated in the hands of this ad hoc committee, which has held several meetings at MSMS headquarters and also met in Washington, D. C. with HEW officials. At its first meeting, the PSRO committee was flanked by detailed maps of Michigan showing the numbers of MDs and DOs, hospital and nursing home beds in the state.



Before the start of the meeting, John R. Wilson, MD, Grand Rapids, chairman, seated, conferred with Kenneth J. Ray, MD, Detroit, committee member. Others on the committee are Mattheis Evans, MD, East Lansing; Daniel J. Fall, MD, Ann Arbor; Donald N. Fitch, MD, Escanaba; James H. Grove, MD, Niles; Leland E. Holly, II, MD, Muskegon; Robert C. Prophater, MD, Bay City; Joseph Rinaldo, Jr., MD, Southfield; Vincent J. Turcotte, Jr., MD, Ann Arbor; Donald G. Blain, MD, Mt. Clemens, and Marion G. McCall, Jr., MD, Detroit.

Here is program for 80th Annual UP Society meeting

Physicians from throughout the Upper Peninsula will gather June 15-16 in Iron Mountain for the 80th annual meeting of the U.P. Medical Society. Chairman John M. Schroeder, MD, Iron Mountain, and his committee have planned a varied program to appeal to family physicians and those in the various specialties.

Following is the program:

Friday, June 15

8:30 a.m. *"Beside examination of the cardiac patient,"* with Arnold Weissler, MD, chairman, Department of Medicine, WSU School of Medicine

9:15 a.m. *"Diagnostic cardiac profiles, with emphasis on the normal,"* with Robert Zeigler, MD, chief, Department of Cardiology, St. Joseph's Hospital, Hancock

10:15 a.m. *"Medical management of hypertension,"* with Ray Gifford, MD, chief, Hypertension Unit, Cleveland Clinic

11 a.m. Cardiology panel

1:30 p.m. *"The status and future of undergraduate medical education in the Upper Peninsula,"* with Donald Weston, MD, associate dean for community and clinical affairs, MSU College of Human Medicine; Donald Smith, MD, principal advisor on health and medical affairs to Governor Milliken; Allegro J. Godley, MD, director, Division of Family Medicine, WSU School of Medicine; Jack Van Tassel, associate director, UP Modular Medical Education Project; Ted Ludwig, MD, chief surgical resident, Blodgett Memorial Hospital, Grand Rapids, and Roland Hiss, MD, Towsley Center for Continuing Education, U-M Medical Center

3:30 p.m. *"The status and future of PSROs in Michigan,"* with Richard Campau, manager, Department of Operations and Peer Review

4 p.m. UPMS business meeting

Saturday, June 16

8:45 a.m. *"Diagnosis and treatment of the common vaginitises,"* with David Anderson, MD, associate professor, Department of Obstetrics and gynecology, U-M School of Medicine

9:30 a.m. *"Facial trauma,"* with Robert Calderwood, DDS, Iron Mountain oral surgeon

10:30 a.m. *"Some remarks on treatment of urinary tract infection,"* with Clair Cox, MD, associate professor of surgery, University of Tennessee School of Medicine

11:15 a.m. *"Some remarks on orthopedic trauma,"* with James Ryan, MD, assistant professor, Department of Orthopedic Surgery, WSU School of Medicine

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In memoriam

Robert E. Bowsher, MD
Midland

The director of medical education for the Midland Hospital Association, Robert E. Bowsher, MD, died March 16 at the age of 59.

Doctor Bowsher had been president of the Midland County Medical Society and a member of the MSMS Committee on Postgraduate Medical Education. Last October he was honored at a recognition dinner by his associates who praised his years of service in advancing postgraduate medical education in his community and state.

Doctor Bowsher had been a private general practitioner in Midland from 1946 until 1965. He was a graduate of Ohio State University medical school.

Doctor Bowsher was past president of the Michigan Association for Medical Education, former director of the Michigan Academy of Family Physicians, past chairman of the executive committee of Midland Hospital, former member of the editorial consulting board of MED-COM, member of the Association for Hospital Medical Education and Association of American Medical Colleges.

He had been a director of the local Visiting Nurse Association and served on the allied health education committee of Delta College and on the president's advisory committee on medical education of Saginaw Valley College.

Leslie U. Hendelman, MD
Troy

Emergency physician Leslie U. Hendelman, MD, Troy, died in a light plane crash March 2. He was 27.

Doctor Hendelman was a graduate of the University of Michigan Medical School and was affiliated with Saratoga Hospital of Detroit.

Leland E. Holly, Sr., MD
Muskegon

The recipient of a 1971 MSMS Certificate of Commendation, Leland E. Holly, Sr., MD, Muskegon, died March 5 at the age of 76. Doctor Holly was honored in 1971 for completing 50 years of medical practice and had been active in community and medical affairs.

Doctor Holly was honored in 1957 as the American Cancer Society's "Man of the Year" for distinguished service in cancer control in Michigan. He was a member of the Michigan Cancer Coordinating Committee, the Committee on Trauma of the American College of Surgeons and on the board of directors and executive committee of the Michigan Division of the American Cancer Society.

Doctor Holly was a past president of the Muskegon County Medical Society, a former MSMS delegate, and former member of the State Board of Registration in Medicine. He also was past president of the Michigan Association of Roentgenologists.

He was a graduate of the University of Michigan Medical School and was on the staffs of six West Michigan hospitals.

Doctor Holly was a diplomate of the American Board of Radiology, and a fellow of the American College of Radiology, and American College of Physicians.

Mary L. Mayer, MD
Mason

Mason pediatrician Mary L. Mayer, MD, died March 10 at the age of 48.

Doctor Mayer was a graduate of the Women's Medical College of Pennsylvania and had practiced in Mason for over five years. Previously, she had taught bacteriology at Michigan State University.

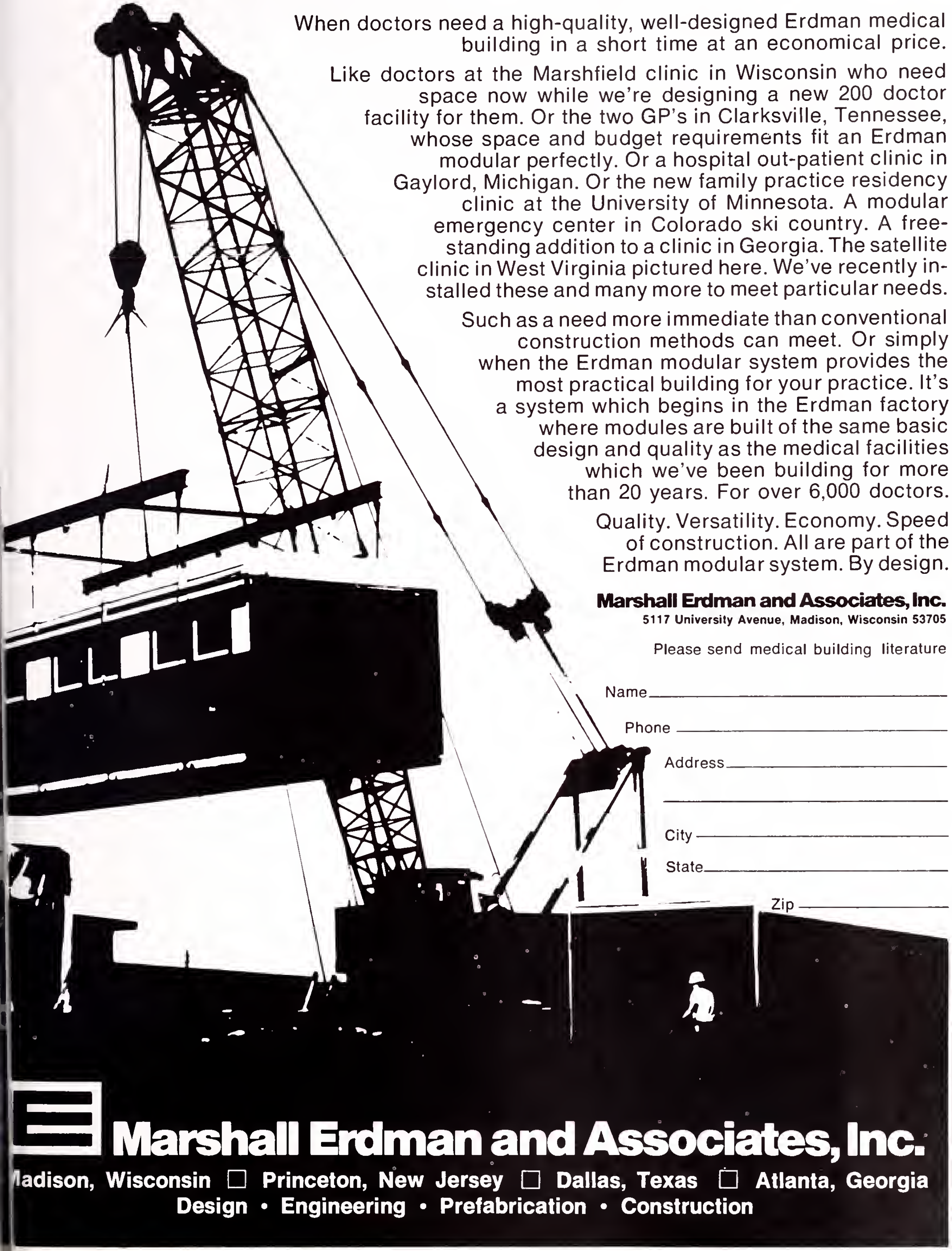
Ervin J. Brenner, MD
Mt. Pleasant

Former Director of the Central Michigan District Health Department, Ervin J. Brenner, MD, died March 26 at the age of 70. Doctor Brenner was head of the health department from 1956 until his retirement in 1965.

Doctor Brenner had been a member of the State Board of Alcoholism, a charter member of the Commission on Aging and former medical director of the local cancer society. He was a fellow of the American Public Health Association and received a Distinguished Health Service Award from the Michigan Health Officers Association.

Doctor Brenner was a graduate of the University of Michigan Medical School and later received a masters in public health from Johns Hopkins University. He had established the first glaucoma clinic in Mt. Pleasant, and was past president of the Gratiot-Isabella-Clare Counties Medical Society.

(Continued on page 394)



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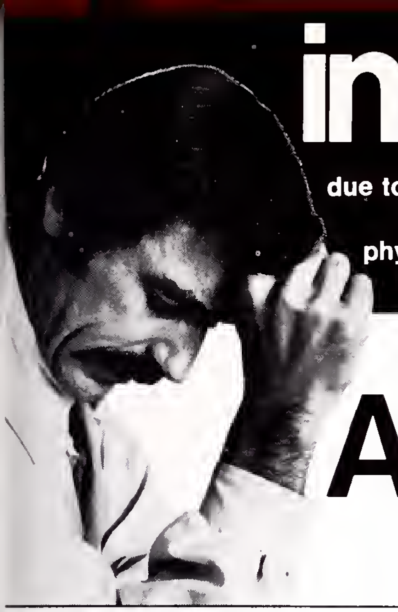

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References 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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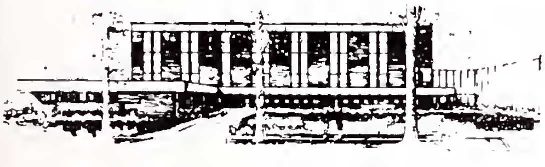

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Michigan mediscene

May 10-11 — Sixteenth Annual Clinic Days, Children's Hospital of Michigan, Detroit Medical Center, contact: Edward W. Green, MD, Children's Hospital, 3901 Beaubien Blvd., Detroit, 48201.

May 10-11 — Annual Gull Lake meeting, MSMS Committee on Maternal and Perinatal Health, Kellogg Biological Station, Gull Lake, contact: Helen Schulte, MSMS headquarters.

May 13 — The Council, Boyne Mountain Lodge, contact: Warren Tryloff, MSMS director, at MSMS headquarters.

May 13-15 — Second Annual Spring Meeting, MSMS House of Delegates, Boyne Mountain Lodge, Boyne Falls, contact: Richard Campau, MSMS headquarters.

May 15-16 — Spring Conference, Woman's Auxiliary to MSMS, Hidden Valley Lodge, Gaylord, contact: Mrs. Fleming Barbour, 2015 Lincoln Drive, Flint, 48503.

May 16-18 — Annual meeting, Michigan Public Health Association, Olds Plaza Hotel, Lansing, contact: Mrs. Anna Langela, executive secretary, MPHA, 403 Seymour, Lansing, 48914.

May 18 — Centennial Luncheon honoring the 100th year of the Michigan Department of Public Health, Olds Plaza Hotel, Lansing, contact: John Cook, Department of Information and Education, MDPH, 3500 N. Logan, Lansing, 48914.

May 18-19 — Spring conference, Michigan Chapter, American College of Emergency Physicians, Shanty Creek Lodge, Bellaire, contact: Arthur Auer, executive director, ACEP headquarters, 241 E. Saginaw, East Lansing, 48823.

May 23 — Council of Specialty Societies, 2 p.m., MSMS headquarters, contact: Glenn E. Moore, MD, president, 323 W. Second, Flint, 48503.

May 24 — Michigan Conference on Rural Health, sponsored by MSMS, Michigan Health Council, MSU at Kellogg Center, East Lansing, contact: John A. Doherty, executive vice president, MHC, 712 Abbott, East Lansing, 48823.

June 1-2 — Annual Keyport Trauma Day, Hidden Valley Lodge, Gaylord, contact: B. E. Henig, MD, 308 Michigan Ave., Grayling, 49738.

June 15-16 — 80th annual meeting, Upper Peninsula Medical Society, Pine Mountain Lodge, Iron Mountain, contact: John Schroeder, MD, 212 E. B. Street, Iron Mountain, 49801.

June 20 — The Council, MSMS headquarters, contact: Warren Tryloff, director.

June 22-24 — Annual meeting, Michigan Orthopaedic Society, Hidden Valley Lodge, Gaylord, contact: George D. Stilwill, MD, 2909 E. Grand River Ave., Lansing, 48912.

June 25-29 — Annual Northern Michigan Summer Course, "Diagnosis and treatment of some common medical problems," sponsored by U-M Department of Postgraduate Medicine at Shanty Creek Lodge, Bellaire, contact: Ralph Lewis, Towsley Center, The University of Michigan Medical Center, Ann Arbor, 48104.

July 6-8 — Regional Conference, American Association of Foundations for Medical Care, Grand Hotel, Mackinac Island, contact: AAFMC, P.O. Box 230, Stockton, Calif., 95201.

July 14-18 — Annual meeting and scientific program, Michigan Academy of Family Physicians, Park Place Motor Hotel, Traverse City, contact: Rita M. Feldkamp, 933 Wing St., Plymouth, 48170.

August 3-4 — Midsummer meeting of The Council, Boyne Highlands, contact: Warren Tryloff, director.

Sept. 19 — The Council, MSMS headquarters, contact: Warren Tryloff, director.

Oct. 7-11 — 108th Annual Session, Sheraton-Cadillac Hotel, Detroit, contact: Helen Schulte, for scientific meeting information, and Richard Campau, for House of Delegates meeting information, both at MSMS headquarters.

IN MEMORIAM/Continued

Leland M. McKinlay, MD
Grand Rapids

Leland Murray McKinlay, MD, Grand Rapids urologist for more than 30 years, died March 15 at the age of 79.

Doctor McKinlay was a native of Vermont and was graduated from the University of Vermont Medical School. He was chief of staff of Butterworth Hospital in the early 1940s and was a member of the Detroit, North Central and American Urological Societies.

Doctor McKinlay retired in 1963 and since had spent his winters in Florida and his summers in Vermont. A craftsman as well as a physician, he had invented an apparatus for determining bladder pressures and an artifical arm for children with physical defects.

George D. Sutton, MD
Flint

Retired Flint physician George D. Sutton, MD, died March 11 at the age of 89.

Doctor Sutton began his practice in Flint in 1930 and previously practiced in Clio. In 1965, he was the recipient of a 50-year pin from the MSMS House. Doctor Sutton had been active in the Flint Community Music Association, Flint Civic Opera and Flint Community Chorus.

MSMS to involve components, physicians in efforts to keep med grads in state

By Herbert A. Auer, Manager
Department of Communications

A series of new activities for MSMS and the component societies designed to help keep more graduates of the three Michigan medical schools in the state for their internships, residencies and new practices was adopted by the May meeting of the MSMS House of Delegates. (See Pages 396 and 397 for the recommendations)

The recommendations were made by an ad hoc committee appointed by MSMS Speaker Vernon V. Bass, MD, after the House adopted a resolution in 1971 voicing concerns about the "emigration of medical graduates." The committee, with George Koepke, MD, Ann Arbor, as chairman, is continuing some research, but meanwhile it has complied with the House directions to present "specific recommendations to help minimize the loss" of Michigan medical school graduates to other states for their internships.

After action by the MSMS House in 1971, Speaker Bass asked the Education Liaison Committee and the Liaison Committee with Medical Students to join as the ad hoc committee because the two groups met the special committee composition spelled out by the MSMS House resolution.

The committee conferred several times with the three medical school deans and their representatives. Chairman Koepke told the House that, "the deans likewise are concerned about the matter and have authorized a cooperative research project. The deans and others have pointed out that it is not proper to contend that many graduates of the three Michigan medical schools leave the state based only on the reports of where they go for their internship training. Certainly some of them return to Michigan for their residency training and/or their actual practice. Exact figures are not available so the deans' research efforts are being continued. The research will follow the graduates of other medical schools who come into Michigan for their internships and residencies, and the movement, too, of foreign-trained physicians. The research also will follow Michigan young people who go to medical schools in other states.

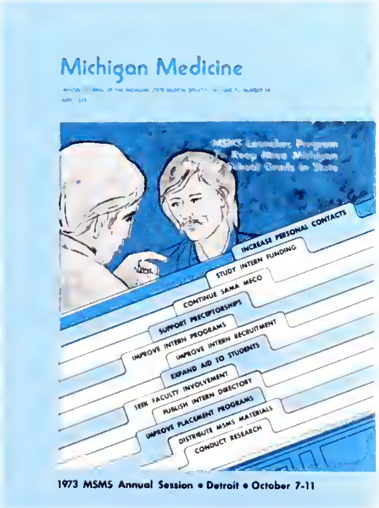
"The conclusion drawn in the resolution that too many graduates of the Michigan medical schools leave Michigan is only part of a more complex subject. Broadly speaking, the resolution raises questions about the movement of graduates, but also about the composition of the physician manpower pool. A detailed analysis is needed and is being undertaken cooperatively by the three medical schools. Information will be studied about the parents' residence, place of high school graduation, place of undergraduate education, marital status, wife's previous address, etc.," Doctor Koepke said.

In recent years the number of new physicians coming to Michigan, but educated and trained elsewhere, tends to equal the number of Michigan medical school graduates who go elsewhere.

The ad hoc committee declared that, "efforts should be made to keep more of our Michigan graduates, but any legislation that would deter the movement of out-state doctors into Michigan would be undesirable and unfortunate."

Old and new decisions by a number of organizations have a direct bearing on this complex subject. These groups include the Council on Medical Education and the House of Delegates of the American Medical Association, the Association of American Medical Colleges, the Liaison Committee on Medical Education of the AMA and AAMC, the administrative board of the Council of Teaching Hospitals, NIRMP, the state medical licensing boards, and others. In Michigan, the groups include MSMS, the three medical schools, hospitals, Michigan Association for Medical Education, the State Board of Registration in Medicine, the legislature.

A related factor in this study and proposed solutions is the fact that the internship, as it has been known generally, will soon be discontinued. By June 30, 1975 all free-standing internships will be eliminated and the first year of graduate medical education, which the internship now represents, will be coordinated with a residency training program and will become the responsibility of the appropriate residency review committee.



14 recommendations adopted by MSMS House to slow down exodus of graduates from state

Following are the recommendations, with brief supporting background, adopted May 15 by the MSMS House of Delegates:

Recommendation 1: MSMS should encourage Michigan hospitals with intern and resident training programs to continue all efforts to make their teaching programs effective and rewarding.

Background: No one will dispute the relationships between the quality of the hospital teaching program and the decisions made by young physicians to select certain hospital and specialty programs over some others. Quality can not be discounted.

***

Recommendation 2: The MSMS Council should continue its study of a possible proposal to the Michigan legislature requesting state appropriations for postgraduate training programs for interns and residents.

Background: Alternative methods of financing postgraduate training are being sought in Michigan and other states. There is support in various circles in Michigan for a program in operation in Indiana where the legislature does fund intern and resident programs. Reports from Indiana indicate the program is a factor in retaining more Indiana graduates in Indiana.

State appropriations, it is believed, would enable teaching hospitals to expand and improve their teaching programs. Such quality improvement should help Michigan training programs to interest more Michigan graduates—and graduates of other U. S. schools.

***

Recommendation 3: MSMS should allocate funds or seek a special grant in order to conduct research to determine why Michigan medical students do or do not take their internship or residency in Michigan.

Background: There is little available data to help this ad hoc committee or future MSMS committees to study this complex subject and offer recommendations based on interviews or opinionnaires.

This ad hoc committee and the deans' research committee has proof that statistics do not exist as a basis for forecasts. Random sample interviews could produce helpful data about attitudes and opinions, that cannot be obtained by merely comparing figures.

***

Recommendation 4: MSMS should continue its summer placement program for students of the three medical schools. (This program is known as the Student American Medical Association — Medical Education Community Orientation.)

Background: The MSMS Council in 1970 approved as a pilot project an MSMS effort to place medical school students in community hospitals to learn first-hand more about the work of the doctor and the operation of the hospitals.

This coming summer, 105 students from the three schools will observe and learn at 52 hospitals.

The reactions from the students, the volunteer MD coordinators, the hospital administrators and the three medical schools have been positive.

The project involves the medical student early in his or her medical school course and likely provides new experiences while he or she is consciously or unconsciously making decisions that will affect life after graduation.

***

Recommendation 5: MSMS should complement the three medical schools and cooperate in the new preceptorship-type programs now being conducted to give students off-campus, person-to-person experiences with family physicians, internists and pediatricians.

Background: The medical schools in 1972 received a federal grant to establish a coordinated, cooperative program of primary care or family practice preceptorships. While the program is very new, ad hoc committee members feel such a program will help retain more graduates of the three schools in Michigan.

MSMS is encouraging interested, qualified physicians to serve as preceptors in this new project.

***

Recommendation 6: MSMS should encourage and assist the Michigan chapters of national specialty societies to explore and conduct projects that will provide more person-to-person, first-hand experiences and relationships with medical students at the three Michigan schools.

Background: The ad hoc committee compliments the Michigan Academy of Family

Physicians for the "Future Family Practice Clubs" operating in Detroit, Ann Arbor and East Lansing and cites this project as one way to accomplish the intent of this recommendation.

***

Recommendation 7: MSMS should encourage the component medical societies in the counties with teaching hospitals to work closely with the directors of medical education, and hospital administrators, to find new ways to recruit more effectively the graduates of the three Michigan schools.

Background: New ways should be explored to involve the local chamber of commerce, banks, auto dealers and realtors, to help recruit medical school graduates and to help them get established when they arrive. The auxiliary especially could help find good ways to interest the wives of married students.

***

Recommendation 8: The MSMS Council should appoint an ad hoc committee to explore ways to make financial assistance available to Michigan medical school students needing such help.

Background: The available financial help at the three medical schools is being strapped now because federal funds for loans and grants have been reduced, because the three schools have more disadvantaged students enrolled and because costs of education and costs of living have increased. Some students do obtain help from component medical societies. Some borrow from the AMA-ERF guaranteed loan program which requires interest payments each year even while the person is in school.

The ad hoc committee has studied possible new programs several times with MSMS Treasurer John Ylvisaker, MD, and members feel various ideas should be explored more vigorously by an ad hoc committee that should include Doctor Ylvisaker.

***

Recommendation 9: MSMS should encourage the deans of the three medical schools to develop ways that the medical school faculty members can know more about the training opportunities offered by Michigan hospitals so the faculty members can effectively counsel the seniors about postgraduate opportunities in Michigan.

Background: This recommendation was made because several research studies show that members of medical school faculties do have both a direct and indirect influence on student internship decisions.

***

Recommendation 10: MSMS should cooperate with other interested groups or take the leadership to publish composite information about the graduate medical education opportunities in Michigan for distribution to students in the three Michigan medical schools and to others who would consider further training and possible future practice in Michigan.

Background: Supporters of the project contend that such a master composite publication is needed and would be valuable.

The ad hoc committee suggested that the MSMS Publication Committee consider publishing this material in *Michigan Medicine* for all physicians, and provide reprints for students and interns.

***

Recommendation 11: The MSMS Council should appoint an ad hoc committee to confer with the Michigan Health Council regarding future operation of the MD Placement Service for Michigan and to report to the fall meeting of the House of Delegates.

Background: Only in Michigan and West Virginia do the state medical societies *not* operate the MD Placement Service for that state. In Michigan, MSMS sponsored the formation of the Michigan Health Council more than 25 years ago and the Health Council operates the MD Placement Service. The ad hoc committee members said MSMS is in a better position to work effectively with the component societies in MD recruitment activities. The ad hoc committee believes that the doctor who comes to Michigan partly as the result of MSMS services would be more apt to join the component society and MSMS than at present.

***

Recommendation 12: MSMS should compile each year the names and mailing addresses of those graduates from the three Michigan medical schools who leave the state for internships and military service, and should send them occasional materials and appeals that they return to Michigan for their residency training and/or for their practice.

Background: Some new graduates decide to go out of state for their internships, but intend to come back later. At present there is no organized contact system in operation.

***

Recommendation 13: MSMS should continue to distribute "Medigram" to the students of the three schools.

Background: The MSMS Medigram newsletter will help the Michigan students learn more about the concerns and efforts of Michigan physicians to serve the public and the profession. This is a complementing type of activity to other more direct keep-'em-in-Michigan projects.

***

Recommendation 14: MSMS should encourage

More Wayne grads stay for internship

The MSMS House of Delegates in the fall of 1971 adopted the resolution about the emigration of medical school graduates after learning that almost six out of 10 graduates from both the University of Michigan and Wayne State University had left Michigan that June for internships in other states. At that time, the new MSU College of Human Medicine had no graduating class.

Statistics presented to the MSMS House this May showed that there has been a decided change in the figures from Wayne State University. The percentage of graduates leaving Michigan to intern dropped from 57.4 per cent in 1971, to 38.9 per cent in 1972, and 30.6 per cent this year. While almost six out of 10 left Michigan in 1971, now only three of 10 of the 1973 graduates will leave the state.

There has been little change in the movement of U-M graduates; 107 of the 185 graduates this year will intern in other states. Whereas 50 per cent of the MSU graduates in 1972 stayed in Michigan, about 40 per cent of the 1973 class will stay in Michigan to intern. (See **Chart 1** for details).

The available figures for 1971 show that of 2,380 doctors in training in Michigan hospitals, 616 were from out-of-state schools and 571 from U-M and WSU, while 1,193 were from foreign schools. 1972 figures are not available.

The statistics also show that of the 8,641 physicians in practice in Michigan in 1971, 3,702 were graduates of U-M and WSU, 4,132 were graduates of other U. S. schools. Another 807 were graduates of foreign schools.

Of the American-educated physicians in training in Michigan, 24.3% are from the U-M and WSU and 25.8% are from other U. S. schools. Together these figures account for 50.1% of all the physicians in training in Michigan as compared to 49.9% being from foreign medical schools.

These figures were developed by the office of Medical Center Planning of the University of Michigan. The data was obtained from the Medical Mailing Service, a contractor for the AMA.

A study made by the MSMS Bureau of Economic Information found that of the 1,286 MDs who received Michigan licenses between July 1, 1969 and July 1, 1971, 40.5% were from U-M and WSU, 38.8% from other U. S. schools and 20.7% were foreign graduates.

A total of 465 residents of the state of Michigan entered medical school in 1970. Of these, 394 entered Michigan schools and 71 entered medical schools outside the state. Of the 71 entering out-of-state schools, 49 entered 23 private schools and 22 entered eight state-sponsored schools.

Total enrollment from all sources in Michigan was 450 in 1969 and up 14.4 per cent to 515 in 1970. In each of the two years, 50 nonresidents were admitted to one of the three medical schools in Michigan, while 61 and 71 Michigan residents respectively were receiving medical education in out-of-state institutions.

Internship Choices
of Michigan
Medical School Graduates

	Remaining in Michigan	Leaving Michigan	Total
1971			
University of Michigan	83 (41.1%)	119 (58.9%)	202
Wayne State University	60 (42.6%)	81 (57.4%)	141
1972			
University of Michigan	82 (45.3%)	99 (54.7%)	181
Wayne State University	77 (61.1%)	49 (38.9%)	126
Michigan State University	15 (50.0%)	15 (50.0%)	30
1973			
University of Michigan	78 (42.2%)	107 (57.8%)	185
Wayne State University	84 (69.4%)	37 (30.6%)	121
Michigan State University	13 (39.3%)	20 (60.7%)	33

RECOMMENDATIONS ADOPTED/Continued

component medical societies to establish and maintain contact with students from their counties who are in pre-med programs or in medical schools.

Background: Such activity could be an indirect reason why a medical graduate might practice later in Michigan. Some counties could be encouraged to experiment with a big-brother approach by matching some interested physician with each of these students. Components could mail their bulletins, could send medical reference books as occasional gifts, could invite students to local meetings during holidays. The possibilities of such component projects should be encouraged.

Editor's note: the above is excerpted from the ad hoc committee report to the House of Delegates.

President's page

John J. Coury, MD
MSMS President

Personally, I feel that one of the greatest challenges facing your component medical societies and MSMS is to make good medical care easily accessible to every resident of Michigan.

The physicians of America through the AMA are on record as firmly believing that every American has a right to access of health care. Our MSMS Council is supporting a major project of the MSMS Committee on Public Relations "To Help People Get a Doctor" or to get medical care.

It is estimated that from five to 20 per cent of Americans do NOT have this access. There are many reasons for this. Some do not know how to get care that may be available to them. Some live in isolated areas. Some may not be able to get to the available care.

We all face a difficult task to improve the distribution of doctors through some voluntary approaches. In the ghettos, it may be quite unsafe for doctors—or the TV repair man, or the delivery man, or even the policeman.

Accessibility to health care is a problem in some rural areas of Michigan, and in such isolated areas as the Appalachian Mountains. The AMA president, Doctor C. A. Hoffman toured Europe and told the AMA House of Delegates last fall that even Russia has poor distribution of doctors. Sweden, which is no bigger than California, has difficulty providing medical services less than 100 miles from Stockholm, he said.

MSMS believes the SAMA-MECO project is helping now to get young students into many Michigan towns during the summer to meet practicing physicians and to learn in our many good smaller hospitals. MSMS placed nine students in 1970 and this year has placed 110 students from U-M, Wayne, and MSU.

The distribution of medical manpower in Michigan and the nation IS improving. But we may not be moving fast enough. We need to find ways to entice physicians into rural areas. MSMS will host the AMA Conference on Rural Health in 1974 so we can learn from others. I am convinced some of the new young doctors would be happy professionally and personally in small towns after they were established.

Muskegon and some towns are making loans to medical students with the provision that repayment will be waived if the student agrees later to practice there. Such programs generally have had little success, but it is worth a try.

What is your county society doing to measure the needs in your area and to keep in touch with your young people in pre-med and medical training?

The AMA president, Doctor Hoffman, has suggested that licensing boards perhaps should give the new doctor a temporary license permitting him to practice in those areas of need that the component society feels have manpower shortages.

How do you react to that proposal?

MSMS is active in many ways. In addition to the summer placement program, MSMS endorsed the 4-year physician assistant program at Western Michigan University; and MSMS is going to move into MD placement work.

MSMS has asked the legislature every year to enlarge our medical schools. This is being done. We now have 956 medical students at the U-M; 742 at Wayne, and 253 at MSU. That's a total of 1,951 medical students today in Michigan.

We need to find new ways to keep these graduates in Michigan. We need also to attract graduates from other states to Michigan. We must find ways, too, to relate better to the many foreign doctors coming to Michigan. There are somewhere between 2,500 and 3,000 foreign graduates in Michigan today. Most of these are in the Detroit area but they are moving into small towns, too, like Onekema, Zeeland and Alma.

Together we must strive to get more doctors for Michigan, try to improve the distribution, and find better ways to make high quality care accessible to all.

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Most people can handle this tension.

Some people develop excessive psychic tension and need your counseling

and a few may need counseling
and the psychotropic action of Valium® (diazepam).

Before deciding to make Valium
liazepam) part of your treatment
lan, check on whether or not the
atient is presently taking drugs
nd, if so, what his response has
een. Along with the medical and
ocial history, this information can
elp you determine initial dosage,
ie possibility of side effects and
ie ultimate prospects of success
· failure.

While Valium can be a most
elpful adjunct to your counseling,
should be prescribed only as long
excessive psychic tension per-
sts and should be discontinued
hen you decide it has accom-
ished its therapeutic task. In
neral, when dosage guidelines
e followed, Valium is well
lerated (see Dosage). For con-
nience it is available in 2-mg, 5-mg
d 10-mg tablets.

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ve been the most commonly re-
rted side effects.

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tients receiving Valium should
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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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Valium®
(diazepam)

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

Circle the dates: MSMS Annual Session is Oct. 7 - 11, 1973

The countdown has begun for the 108th Annual Session of the Michigan State Medical Society. The five-day annual meeting is scheduled Oct. 7-11 at the Sheraton Cadillac hotel in downtown Detroit.

As usual, the Annual Session will begin with three days of meetings Sunday-Tuesday, Oct. 7-9, for the MSMS House of Delegates.

Highlighting their deliberations on resolutions affecting key medical issues will be special ceremonies installing new MSMS President Brooker L. Masters, MD, Fremont; selection of the MSMS president-elect, awards presentations and the recognition of Michigan physicians who have served 50 years as medical doctors.

The two-day Scientific Session on Wednesday and Thursday, Oct. 10-11, will have a new look, with nearly all programs prepared and organized by Michigan medical specialty organizations.

The new format was approved and put into motion by the MSMS Council in December, 1972, following the recommendation of physician-coordinators of the 1972 Annual Scientific Session, Richard Judge, MD, and Robert L. Tupper, MD. MSMS will provide program grants and assistance in overall planning.

The meetings will be open to all interested physicians, and as in the past, all scientific sessions will be free of charge to all MSMS members, medical students, and interested ancillary personnel.

Program coordinator for the 1973 Scientific Sessions is John B. Bryan, MD, Royal Oak internist and private practitioner. He previously served as co-coordinator of the 1971 MSMS Scientific Session.

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Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.

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For complete details, including dosage, please see full prescribing information.

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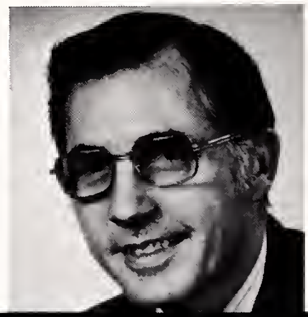
Opinion & Dialogue

"Prescription drugs – who should determine the maker?"

Dispenser of Medicine

Clifton J. Latiolais
President
American Pharmaceutical Association



"Too many doctors are indiff
ent to the economic consequence
their decisions." So stated a recer
issue of *Medical News Report* (De
cember 4, 1972), an independent
weekly newsletter published by for
AMA Chief Executive F. J. L. Blasir
game, M.D.

Doctor, are you indifferent . . . ?

In discussing an anticipated
crease in Blue Shield rates, Dr. Bl
ingame's newsletter had this to sa

"In general, it can be said, M
have given the impression they ar
not particularly concerned with th
increase in cost of health care to t
patients . . .

"True, an MD's training is pr
marily scientific, but in the real w
of practice, all of his scientific de
sions have a price tag, or an econ
impact. The economics of health
beckon the practitioner's attentio
Concern for economics of medici

Maker of Medicine

C. Joseph Stetler
President
Pharmaceutical Manufacturers Association

When the pharmacist recom
mends that a drug product other t
the one ordered be dispensed, th
prescriber invariably permits the
change when he feels the best int
ests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is ne
sary for the prescriber to know th
the change is being contemplated
and to be in a position to consent
demur. Without that opportunity,
unilateral decision of the pharma
made in the absence of clinical kn
edge of the patient, could expose
to needless risks, and in addition,
jeopardize the relationship betwe
the professions of Pharmacy and
Medicine. In my view, there is not
in the pro-substitution argument
offsets these risks.

The Issue of Drug Knowledge

Substitution advocates clai
that the primary justification for
changing the rules is the desire t
better utilize pharmacists' knowl
about drugs. Yet the pharmacist'
task to keep current on the entire
field of drug therapy, to some de
puts him at a disadvantage. Most
often, a practicing physician will
expert knowledge of no more tha

Advertisement

ould be an obligation of medical
ctice...

"Medical societies ought to con-
ct continuing campaigns to point
the substantial savings that could
realized thru deductible insurance
d protection for catastrophic ill-
s. At the very least, they should, in
patients' interest, question the
tics of any insurance organization
t raises health care costs by forc-
policyholders to buy insurance
y may not need or want and prob-
y won't ever use.

"Too many doctors are indiffer-
to the economic consequences of
ir decisions. Too many, for ex-
ple, habitually hospitalize patients
the convenience of the MD. It's
nsense to deny such habits exist...

"Doctors, thru their medical so-
ies, have unhesitatingly appealed
neir patients for support in the
t against government interference
n the private practice of medicine.
d the public in the past has re-
nded. It's time the American Med-
Association and state and local
dical societies paid off the debt by
isive action to hold down the cost
nedical care."

t of Drugs

Insurance rates and hospital
rges are only two factors in health care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists *are concerned*. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

---

0 drugs that he selects to treat the
ority of conditions encountered in
practice. Moreover, the physi-
n's choice of a specific brand is
ed on his knowledge of the pa-
t's medical history and current
dition, and his experiences with
particular manufacturer's
duct.

Some substitution proponents
e argued that the dispensing of a
scription is a simple two-party
saction between the pharmacist
the patient, and that a substitut-
pharmacist may avoid even a
nical breach of contract by simply
fying the patient that he is making
substitution. I would judge that
courts would be sympathetic
rd a pharmacist who substituted
out physician approval and who
ertook a legal defense that seeks
ake the patient responsible for
pharmacist's actions.

uced Prescription Prices?

Substitution advocates are
gesting to the consumer, and par-
arly the consumer activist, that
uced prescription prices could
w legalization of substitution.
have seen absolutely no evidence
stify this claim. To the contrary,
rience in Alberta, Canada, where
stitution is authorized, suggests the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advocates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

*Pharmaceutical
Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005*

P·M·A

ABBOTT

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Brief Summary

Indications—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

Contraindications—Drug hypersensitivity and porphyria.

Warnings—Not recommended during the first and second trimester of pregnancy. Caution patients of possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

Precautions—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitryptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

Adverse Reactions—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 306433

Give us his nights.

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(ETHCHLORVYNOL CAPSULES, 500 or 750 mg.)

Community, university hospitals should cooperate to best meet continuing education needs

By C. R. Shelton
Detroit

Continuing medical education and graduate medical training are much discussed subjects in these days of unparalleled changes in our professional, educational and social structures.

And as various calls for requiring proof of continuing medical education become stronger in many areas, graduate study—of whatever type—grows in importance.

Most of Michigan's continuing and graduate medical education is done in large, metropolitan community hospitals, and directors of medical education at such hospitals have become increasingly visible in the daily activities of both house and staff physicians.

"Whenever possible community hospitals should be deeply involved in programs of graduate and continuing medical education," declares John W. Moses, MD, director of medical education at Mt. Carmel Mercy Hospital, Detroit, since 1966.

"The most important reason for producing physicians," Doctor Moses says, "is to take care of community medical needs. And the most important reason for graduate training is to service the community. It is important to note, too, that the majority of interns and residents tend to remain in the geographical area in which they were trained; so a physician who trains in a community hospital probably will stay in that area and help meet future medical needs."

An internist with a subspecialty in hematology, Doctor Moses is closely involved with all phases of medical education at Mt. Carmel. He teaches classes, and participates, in some way, in most others. While the teaching program is the responsibility of Mt. Carmel's chiefs of services, Doctor Moses works with them all in an advisory capacity, helping assay their programs in comparison with other programs.

"Michigan is a national leader in graduate and continuing medical education done in community hospitals. It is rare to find a large, Michigan hospital (more than 400 beds) that does not have a medical education department."

At Mt. Carmel, a 559-bed hospital, there are 325 attending staff members and 99 on the house staff. The house staff spends from 30 to 40 percent of the time in formal or didactic class work, with the remainder devoted to gaining experience in actual clinical patient care.

All teaching is conducted by the attending staff. Much is done on a volunteer basis; however some participation is scheduled as a requirement for continuing staff appointment.

"We seem to have an ideal arrangement here, because our graduate and continuing education are so closely linked. Whether we are engaged in formal classes or clinical work, we are always learning, and the individuals who are teaching students are, at the same time, teaching themselves," Doctor Moses explains.

Such teaching could become even more important since some states are in the process of requiring more and more proof of continuing medical education. Doctor Moses believes there are many ways to satisfy these requirements, and that community hospital teaching can be a definite asset.

"Requirements should give physicians points for papers that they produce, for actual teaching that they do, and for the continuing education they experience in their hospitals," he says.

Doctor Moses foresees many changes ahead in community hospital medical education, as the mix of U.S.-trained versus foreign-trained physicians shifts.

"For several years there were more house staff positions available in the United States than candidates, and there has been a shortage of physicians all over the country.

"This of course, caused the ingress of foreign medical graduates. Community hospitals had to rely more on them than on U. S. graduates. And

(Doctor Moses is currently running for a seat on the AMA Council on Medical Education.)

John W. Moses, MD
Scientific Editor

(Editor's Note: To provide this article about the growing interest among hospitals in graduate and continuing medical education and in the emerging roles of the director of medical education, Michigan Medicine *assigned C. R. Shelton, freelance medical writer in Detroit, to visit a typical metropolitan community hospital and interview the DME.)*

we, naturally, had to gear our medical training to their specific needs.

"During the coming years, there will be more U.S. graduates and a reduction of foreign graduates coming to this nation. There will be vast changes in financing and structuring of graduate medical education programs," Doctor Moses predicts. "At the same time many people hope to restrict the number of physicians trained for subspecialties and place more emphasis on primary care physicians, which will necessitate more changes."

Noting that some feel universities should take over graduate education, Doctor Moses points out that only one of every six patients hospitalized in the U.S. is in a university hospital.

The remainder, for the most part, are cared for in community hospitals. Therefore there is a markedly apparent need for the exposure of these students to the practice of medicine in community hospitals.

"Also since the majority of attending physicians are in community hospitals rather than university hospitals. the need for continuing medical education at the community hospital level is observable."

Doctor Moses, who earned his M.D. at Boston University School of Medicine, did his internship at Beverly Hospital, Beverly, Mass., and residency in internal medicine at Boston Veteran's Administration Hospital, stresses the fact that community hospitals cannot cover every graduate educational need—such as all subspecialties, or all basic science requirements.

"Total graduate training and continuing medical education is difficult for a community hospital to accomplish entirely on its own; conversely it is impossible for a university hospital, alone, to do it.

"The best way, I believe, to meet these pressing needs is for community and university hospitals to cooperate closely and give the best of what each has to offer. University hospitals do not see the majority of hospital patients and the everyday sicknesses, such as coronaries and ulcers. However, community hospitals do not deal, to any great degree, in the so-called exotic cases.

"Both types of hospitals have a great deal to offer medical education without robbing the other of its identity or purposes. We both need to offer that in which we excell, with the common goal of serving the community's medical needs in the best way possible," Doctor Moses adds.

Michigan continues to gain doctors; but some specialties lose numbers

Recent figures of the AMA center for Health Services Research and Development reveal increases in the number of total Michigan physicians, with decreases in some specialties. The AMA Center's figures compare Dec. 31, 1970, with December 1971.

The Michigan Health Council reports a further increase of physicians since that time, with 330 more doctors licensed in Michigan in 1973 than in 1972.

Since 1968, says the Health Council, Michigan has gained 1,222 physicians, with all regional areas showing an increase.

Total physicians in Michigan as of Dec. 31, 1970, were 10,982, the AMA Center reports, while one year later the state had 11,454 total MDs. Of those, 6,776, as of Dec. 31, 1971, were in office-based patient care, 3,171 in hospital based practices, 854 in other professional activities, 472 inactive and 81 not classified.

Medical specialties were the fields for 2,672 active physicians as of Dec. 31, 1971; surgical specialties that of 3,329 physicians, and an additional 3,068 physicians were in other specialties.

Significant gains in numbers of physicians were made by the specialties of internal medicine, pediatrics, neurological surgery, urology, anesthesiology and radiology.

Numerical losses were registered in Michigan between Dec. 31, 1970, and Dec. 31, 1971, by the specialties of general practice, allergy, cardiovascular diseases, gastroenterology, colon and rectal surgery, child psychiatry, occupational medicine, physical medicine and rehabilitation, and therapeutic radiology.

Currently, the Michigan Health Council reports, Washtenaw County has the best ratio of medical doctors per population with one MD for every 227 residents. Washtenaw is followed by Emmett County, one per 296; Grand Traverse, one per 412; Luce, one per 566; Oakland, one per 585; Dickinson, one per 792 and Marquette, one per 924.

Oakland County gained 141 MDs during the past year and Wayne one, ending a trend which has seen Wayne's physician population reduced yearly from 3,263 ten years ago to 2,714 today.

Other counties which have registered sizeable gains in physician numbers during the past year include Washtenaw, 53 more physicians; Macomb, 32 more; Ingham, 28 more.

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A case report

Leiomyosarcoma of the broad ligament

Alexander S. Ullmann, M.D.
Theodore L. Roumell, M.D.
Rochester

Primary malignant tumors of the broad ligament, particularly sarcomas, are very rare. A review of the recent literature revealed only a single reported case of sarcomatous degeneration of a leiomyoma.[1] Recently we had the opportunity to study a patient with primary leiomyosarcoma of the broad ligament. The rarity of this tumor warrants the presentation of the following case.

Case Report

A 50 year old white female, #50515, was admitted to Crittenton Hospital in November, 1972 for excision of a large pelvic mass. She complained of progressive pelvic pressure pain of four months duration, associated with general malaise, anorexia, and urinary frequency. Her past history indicated menarche at the age of 11 with regular menses, 28 to 30 days, lasting five days. An infertility work-up many years ago revealed no abnormalities, but she has never conceived. In 1961, she had a D & C followed by posterior colpotomy and uterine myomectomy. The tumor was histologically benign.

Two breast biopsies in the past 10 years showed bilateral fibrocystic disease. Since her menopause in 1967, she experienced two to three days of withdrawal bleeding each year due to estrogen replacement therapy. During the past four years she also had recurrent episodes of cystitis which have been treated successfully each time. At first the present frequency was thought to be another recurrence of the cystitis until its association with the pressure sensation in her pelvis became obvious. There was no history of allergies, tuberculosis, malignancy, rheumatic fever, or syphilis. Her family history revealed a sister and mother who died of uterine and bowel carcinoma, respectively.

On physical examination the patient was well developed, well nourished and appeared in no acute distress. The blood pressure was 130/75, pulse 80 per minute, temperature 98.2 F. Pelvic examination showed nulliparous introitus and good estrogen support of the vaginal mucosa. The cervix was posterior in position and normally epithelialized. Bimanual examination revealed the uterus to be anterior, displaced by a large pelvic mass, predominantly on the left, and filling the posterior pelvis. The remainder of the physical examination was essentially negative.

Laboratory findings on admission: Hemoglobin 12.6 grams per 100 ml., hematocrit 38.2%, white blood count 6,600 per cubic millimeter, VDRL nonreactive. Urinalysis and SMA-12 were normal. Chest x-ray was negative. Barium enema showed the sigmoid segment of the colon to be distorted and deformed by a mass in the pelvis, pushing the sigmoid backwards and to the left. There was no sign of an intrinsic colonic lesion. Flat film of the abdomen revealed an ill-defined soft tissue density in the pelvis. Intravenous pyelogram showed unremarkable kidneys and ureters on both sides, but there was an indentation on the superior aspect of the bladder by an extrinsic pelvic mass. No intrinsic filling defect was seen. An electrocardiogram was within normal limits.

At laparotomy a large nodular tumor was found filling the cul-de-sac. The mass which was solid in some areas and cystic in others, originated from the left broad ligament and was adherent to the left ovary, to the adjacent loops of small bowel and it invaded the wall of the sigmoid colon. The adhesions to the small bowel and to the left ovary were freed mostly by blunt dissection and the mass was removed in its entirety. The involved portion of the sigmoid colon was resected, extending from slightly below the peritoneal reflection to 10 cm. above it, with primary end-to-end anastomosis. Total hysterectomy with bilateral salpingo-oophorectomy was then performed. The postoperative course was uneventful.

Pathology

The tumor mass which measured 11 x 7.5 x 6.5 cm. and weighed 250 grams was rather soft in consistency. It did not seem encapsulated and its surface was lobulated. Most of the tumor was grayish-white and soft, partly solid and partly cystic in appearance. The central portion showed yellowish necrosis surrounded by areas of hemorrhage. The uterus which measured 7 x 3.5 x 3 cm., contained

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Scientific articles

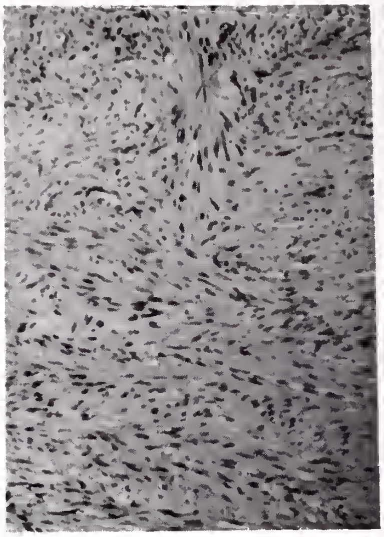

Fig 1A. Better differentiated portion of the leiomyosarcoma. Spindle shaped cells with elongated nuclei show palisading (H & E x 100).

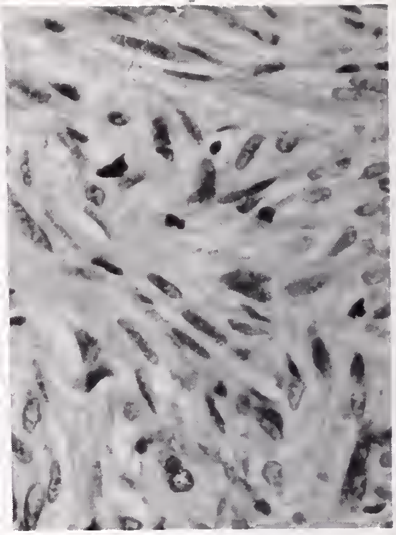

Fig. 1B. Higher magnification demonstrates cellular pleomorphism (H & E x 450).

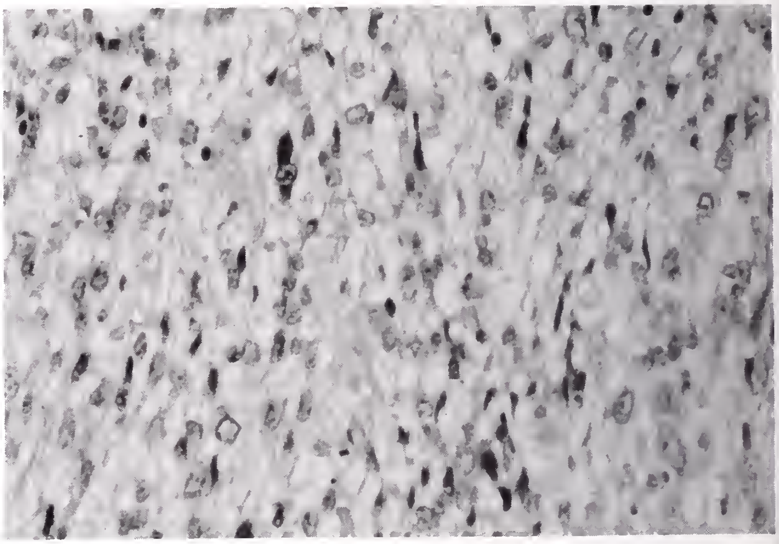

Fig 2. Area of the tumor composed of polygonal cells with vacuolated cytoplasm (H & E x 450).

several intramural fibroids which ranged in size from 0.8 to 1.5 cm. These nodules were well circumscribed and their cut surfaces were grayish-white and bosselated. The ovaries and tubes showed no gross abnormalities.

Microscopic examination

The tumor was composed mainly of long spindle shaped cells which were arranged in many areas in interlacing fascicles. The nuclei were elongated with blunt ends. In some portions the tumor cells were relatively uniform. In these better differentiated areas the nuclei appeared to be aligned in parallel rows (**Fig. 1**). Some less well differentiated parts were composed almost entirely of polygonal cells with large vacuolated cytoplasm (**Fig. 2**). The poorly differentiated areas contained giant cells, strap cells, ovoid to polygonal cells of varying sizes, and small round cells with hyperchromatic nuclei. Mitotic figures were noted in moderate number (**Fig. 3**). These poorly differentiated portions revealed multiple foci of degeneration and hemorrhagic necrosis. On some of the sections the tumor appeared to be partially surrounded by a fibrous pseudo-capsule (**Fig. 4**). The microscopic picture was that of a leiomyosarcoma with varying degrees of differentiation in different areas. A portion of the tumor invaded the muscularis of the sigmoid colon. The overlying large bowel mucosa appeared intact.

The cells of the uterine leiomyofibromas were uniform in shape and size, and showed no evidence of malignancy. The endometrium was in the proliferative phase; multiple foci of adenomyosis were found within the endometrium. Both ovaries contained corpora albicantia. The fallopian tubes were unremarkable.

Discussion

In their comprehensive study, Gardner and his associates defined tumors of the broad ligament as those which occur in or on the broad ligament, but are completely separated from and are in no way connected with either the uterus or the ovary.[2]

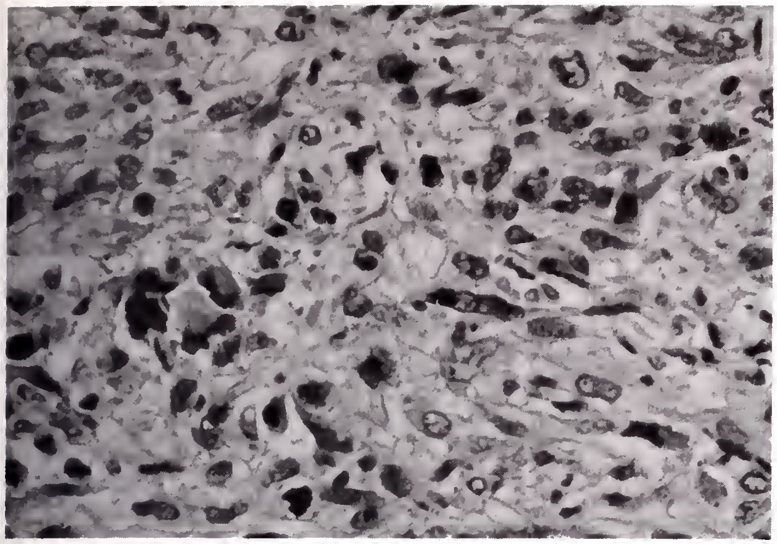

Fig 3. Undifferentiated portion of the tumor demonstrating giant cells, strap cells and mitotic figures (H & E x 450).

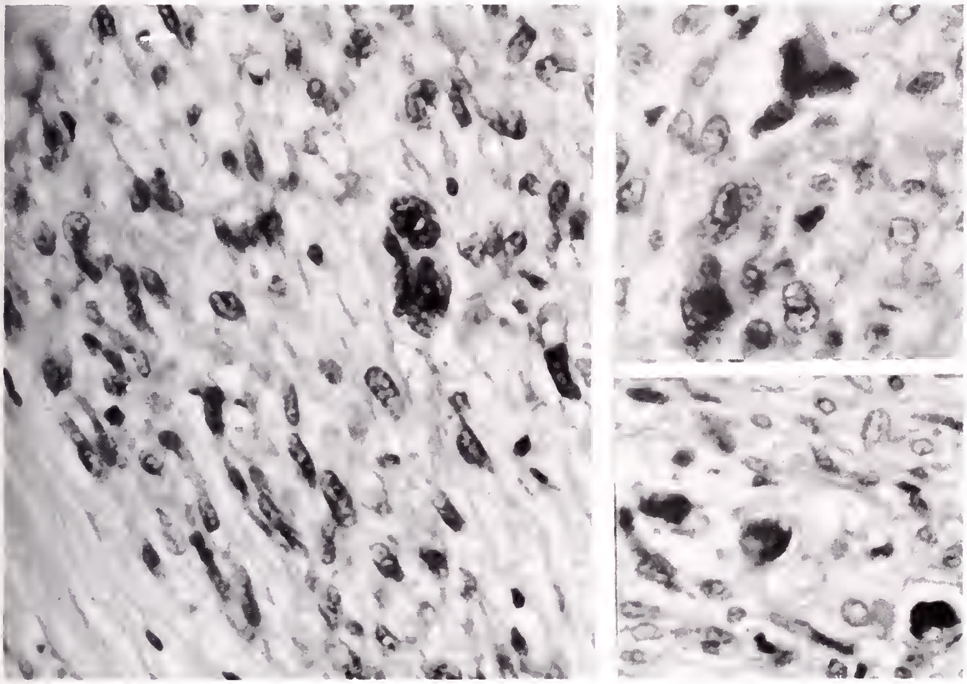

Fig 4. Fibrous pseudo-capsule partially surrounding a poorly differentiated portion of the tumor. Inserts: Bizarre tumor cells (H & E x 450).

They excluded all myomas in which there was the slightest question either of extension from or connection with the uterus. Not a single case of sarcoma was found in their series of 27 tumors. Around the turn of the century German and French authors described several cases of sarcoma at this site,[3] the first one having been reported by Schmidt in 1878.[4] Since most of these authors did not adhere to Gardner's above mentioned criteria, the primary or secondary nature of these tumors appears somewhat questionable. Review of the more recent literature revealed only a single reported case of a sarcoma arising in a leiomyoma of the broad ligament.[1]

In the case we are presenting there was no gross or microscopic evidence of a preexisting leiomyoma, and the origin of the sarcoma in the broad ligament was unquestionable. Different areas of the tumor showed varying degrees of differentiation, and apart from the obvious sarcomatous histologic appearance, its malignancy was demonstrated by the invasion of the sigmoid colon. The mass was completely separate from the uterus and the right ovary; the left ovary which was attached to it by fibrous adhesions could be easily separated. Careful examination of both ovaries, tubes, and of the uterus failed to demonstrate either primary or secondary involvement. The leiomyofibromas of the uterus were definitely benign histologically, and showed no evidence of sarcomatous degeneration.

Summary

A 50 year old postmenopausal white woman underwent laparotomy for a large tumor of the left broad ligament which was adherent to adjacent loops of small intestine and invaded the wall of the sigmoid colon. Microscopically, the tumor was a leiomyosarcoma showing varying degrees of differentiation.

Abstract

A 50 year old postmenopausal white woman underwent laparotomy for a large tumor of the left broad ligament which was adherent to adjacent loops of small intestine and invaded the wall of the sigmoid colon. Microscopically, the tumor was a leiomyosarcoma showing varying degrees of differentiation. A review of the literature revealed only one similar case in recent times, although several others were described by European authors around the turn of the century.

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Bathing bronchitis

By Norman S. Levy, MD
Gainesville, Fla.
Edward T. Stern, BS
Muskegon, Mich.

Abstract

A symptom complex consisting of sudden bronchial irritation and reflex coughing developed in four persons one hour after swimming in the waters of Lake Michigan near Muskegon. The cough disappeared within a few hours but the bronchial irritation persisted for several days. Inquiry revealed that on warm humid days similar illness often had occurred in residents of the area (usually young, healthy adults or children without any allergic or respiratory history). Although the etiologic cause of this illness is unknown, evidence indicates the strong possibility of a toxic water pollutant and studies are now in progress to characterize it.

The investigations of Fry,[1] Huber, et al.[2] and Davies,[3] alerted physicians to the possibility of toxic respiratory damage caused by environmental pollutants. Although most reports have dealt with severe, sometimes lethal disease which required hospitalization and vigorous therapy, the individuals affected were usually debilitated or otherwise predisposed to respiratory difficulty. It has been difficult, however to demonstrate any consistent relationship between environmental pollutants and respiratory illness in normal populations.[1]

This report describes an acutely developing bronchial irritation observed in four young healthy members of a family, one hour after swimming in the waters of Lake Michigan near Muskegon. It also documents similar complaints from residents of the area which indicate the presence of a public health problem for several years.

Observations

This study was undertaken after one of us (NSL) observed the sudden onset of raspiness of the throat, bronchial irritation, and reflex coughing in himself and three other members of his family one hour after swimming in Lake Michigan, south of Muskegon at Hoffmaster State Park. Two other members of his family and three others in the party who did not enter the water were completely free of symptomatology.

The symptoms consisted of sudden development of bronchial irritation, made worse with deeper respirations, resulting in involuntary spasms of coughing. There was associated pharyngeal and conjunctival injection and irritation. The cough tended to disappear within a few hours, but the bronchial irritation persisted for several days. The four persons affected (ages range from four through 32 years) did not smoke or have any history of allergies or respiratory diseases.

Inquiry revealed that this "illness" has been known to residents of the Muskegon area for many years. Symptoms were usually experienced shortly after strenuous effort in or near the beach areas, especially on warm and humid days. Children and young adults seemed most frequently involved, perhaps because of the association with exercise. Symptoms were also reported to occur after exertion on playing fields, where processed sand from foundries is used for fill.

A survey of residents of the Muskegon area was made in order to understand the nature, frequency, predisposition to, and sequelae of this respiratory illness. The results are presented in **Table I** and **Table II.** They suggest that young males most frequently display these symptoms of bathing bronchitis following strenuous activity during warm, moist weather.

Discussion

Many air contaminants have been implicated as a cause of respiratory illness. The correlation between smoke and sulfur dioxide levels in the air and the respiratory difficulty is well known.[3 4 5] Factors such as ether-soluble aerosols and dust[2] may play a significant role. Nitrogen dioxide can cause bronchiolar inflammation and increased susceptibility to infection in experimental animals.[6 7]

Oxidized nicotine will cause almost complete ciliostasis in specially treated human epithelial cells[8] and the carcinogenic effect of cigarette smoking is well documented.[9] In addition, the production of nitrogen compounds, carbon monoxide, and ozone from automobile exhausts contributes significantly to respiratory illness.

The respiratory symptoms in bathing bronchitis experienced by residents and visitors to the Muskegon area appears to require exertion in warm, moist air. Those experiencing this illness have no known predisposing characteristics. This suggests the presence of a toxic substance which finds access to the respiratory epithelium either directly from the water or via its dissolution in the air.

Muskegon is a highly industrialized community. The waters of nearby Lake Michigan serve as repository for industrial waste from foundries, paper mills, and numerous other plants. Problems with human waste disposal have lead to experimentation in sewage recycling.

Doctor Levy is assistant professor in the Department of Ophthalmology, The University of Florida. Mr. Stern is a graduate student, Michigan State University, Department of Biology.

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Table I Survey of Visitors to Hoffmaster State Park
Muskegon, Michigan

	No Interviewed	Avg Age Yrs	Sex		Smoker		Allergies		Lung Disease		Resident of Muskegon	
			M	F	Yes	No	Yes	No	Yes	No	Yes	No
Bathing Bronchitis	38	23.3 s.d. = 7.9	33	5	11	27	9	29	1	37	32	6
No Bronchitis	29	34.2 s.d. = 13.6	19	10	10	19	9	20	1	28	28	1
Total	67	27.9 s.d. = 10.7	52	15	21	46	18	49	2	65	60	7

Table II
Conditions of Symptom Development

Activity		Location			Climate			
Strenuous	Sedentary	Beach	Playing Field	Other	Moist	Dry	Hot	Cold
36	2	20	3	15	17	2	21	4

The part at which this syndrome was first noted is located south of Muskegon Lake channel. Its beaches, upon which can be found putrefying alewives, reflect the gravity of the pollution problem.

To date, no evidence exists to implicate a specific pollutant as the cause of bathing bronchitis. Studies are now in progress to characterize the cause of this respiratory illness. Further study is required to determine what, if any, long term implications this illness may have on residents of the Muskegon area. The cumulative effect of smoking and air pollutants, amply documented in many studies,[3,4] makes long term evaluation of bathing bronchitis an important matter to public health.

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Carcinoma of the female breast in a rural community hospital

By William D. Baxter, MD
Hastings

The primary treatment of carcinoma of the female breast continues to stir controversy. Since the description of the radical mastectomy 80 years ago, discussion has been lively. Many series of patients treated in a standard way have been studied. This is a non-standardized group treated in a small rural community hospital. A high percentage of long-term followup has been obtained.

Method

From January 1, 1955 to December 1, 1972, 122 women have received surgical therapy of 126 primary carcinomas of the breast at Pennock Hospital. It is a 105-bed institution in a small rural community.

The surgical therapy was individualized by the characteristics of the lesion, patient, and surgeon. The specific operations and their frequency are summarized in **Table 1.** Approximately one-half of the patients had a simple mastectomy, and the other one-half had a radical mastectomy.

Table 1

Operation	Number	Percent
Local Excision	3	2.4
Simple Mastectomy	56	44.0
Radical Mastectomy		
Modified	16	12.7
Classical	51	40.9
	126	100.0

Post-operative irradiation was frequently utilized but in a non-consistent pattern. No post-operative chemotherapy was given, and no oophorectomies were done.

Lymph nodes were studied in 24 cases (only after 1965), and they were involved in neoplasm in 38 per cent.

During this period an additional five women were seen with advanced carcinomas deemed inoperable. All of these women died within two years of their clinical diagnoses.

Results

Followup information was obtained from the patient, family, family physician, or surgeon. 120 (95.2%) were followed until death or November 30, 1972. There was no operative mortality. The patients who were lost to followup were excluded. The survival rates are tabulated in **Table 2.** 64% survived five years, and 41% survived 10 years.

Table 2

Year	No. of Patients	Followed	Alive	Percent
1	120	118	100	84.4
2	116	113	86	76.2
3	113	108	75	69.4
4	102	96	63	65.6
5	94	86	55	63.9
6	86	81	48	59.1
7	75	70	34	48.6
8	63	58	23	39.6
9	55	51	19	37.2
10	46	42	17	40.5

Discussion

A sampling of the five and 10 year survival studies from standardized treatment series are shown in **Table 3.** Our five year survival rate of 64% falls well between the 35-72% figures, and the 10 year survival figure of 41% is within the 37-60% range observed.

Table 3

Treatment	Survival 5 Years	 10 Years
Simple Mastectomy	45%[1]	37%[2]
Modified Radical Mastectomy	60%[1]	45%[2]
Radical Mastectomy	60-72%[1]	46-60%[2]
Supraradical Mastectomy	70%[1]	51%[2]
Mastectomy, axillary dissection, and irradiation	63%[1]	53%[2]
Simple Mastectomy and irradiation	64%[1]	47%[2]
Irradiation	35%[1]	
Present series	64%[1]	41%[1]

These figures suggest that there is no valid reason to adhere strictly to one procedure in the treatment of breast cancer, and that a flexible ap-

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The author is Chief of Surgery at Pennock Hospital in Hastings.

Michigan mediscene

June 6-7—Annual meeting, "The Adolescent—Mind and Body," Michigan Chapter, American Academy of Pediatrics, Hidden Valley Lodge, Gaylord, contact: Robert M. Bookmyer, MD, program chairman, 31815 Southfield Road, Birmingham, 48009

June 8—Neuromuscular disease symposium, sponsored by Greater Metropolitan Detroit Area Chapter, Muscular Dystrophy Association of America, Inc., at Kellogg Center Michigan State University, East Lansing, contact: Continuing Education Service, Kellogg Center, MSU, East Lansing, 48823.

June 13-16—22nd Annual Conference, Michigan Association for Retarded Children, Rackham Building, The University of Michigan, Ann Arbor, contact: Harold G. Coil, chairman, MARC, 510 Michigan National Tower, Lansing, 48933

June 14—Panel discussion, "Human sexuality and Health Care Professional," Sinai Hospital of Detroit, contact: Norman Rosenzweig, MD, Chairman, Department of Psychiatry, Sinai Hospital, 6767 W. Outer Drive, Detroit, 48235

June 15-16—80th Annual Meeting, Upper Peninsula Medical Society, Pine Mountain Lodge, Iron Mountain, contact: John Schroeder, MD. 212 East B. Street, Iron Mountain, 49801

June 20—The Council, MSMS headquarters, contact: Warren Tryloff, director

June 22-24—Annual meeting, Michigan Orthopaedic Society, Hidden Valley Lodge, Gaylord, contact: George D. Stilwill, MD, 2909 E. Grand River Ave., Lansing, 48912

June 25-29—Annual Northern Michigan Summer Course, "Diagnosis and treatment of some common medical problems," sponsored by U-M Department of Postgraduate Medicine, at Shanty Creek Lodge, Bellaire, contact: Towsley Center, The University of Michigan, Medical Center, Ann Arbor, 48104

July 6-8—Regional Conference, American Association of Foundations for Medical Care, Grand Hotel, Mackinac Island, contact: AAFMC, PO Box 230, Stockton, Calif., 95201

July 13-15—Annual meeting, Michigan Psychiatric Society, Grand Hotel, Mackinac Island, contact: R. Norman Rosenzweig, MD, Chairman, Department of Psychiatry, Sinai Hospital of Detroit, 6767 W. Outer Drive, Detroit, 48235

July 14-15—Summer Seminar, Michigan Branch, American Association of Medical Assistants, Grand Hotel, Mackinac Island, contact: Mrs. Louise Cole, 215-A S. Main, Ann Arbor, 48108

July 14-18—Annual Meeting and scientific program, Michigan Academy of Family Physicians, Park Place Motor Hotel, Traverse City, contact: Rita M. Feldkamp, 933 Wing St., Plymouth, 48170

July 26-27—53rd Annual Coller-Penberthy-Thirlby Medical Conference, Park Place Motor Inn, Traverse City, contact: Lawrence P. Skendzel, MD, Munson Medical Center, Traverse City, 49684

Aug. 3-4—Midsummer meeting of the Council, Boyne Highlands, contact: Warren Tryloff, director

Sept. 19—The Council, MSMS headquarters, contact: Warren Tryloff, director

Oct. 7-11—108th Annual Session. Sheraton-Cadillac Hotel, Detoit, contact: Helen Schulte, for scientific meeting information, and Richard Campau, for House of Delegates meeting information, both at MSMS headquarters

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CARCINOMA OF THE BREAST/Continued

proach is the proper one. There are however no clear-cut guidelines at this time to direct the surgeon in his choice of procedure.

Conclusions

A nonstandard approach to the surgical therapy of women with carcinoma of the breast in a small rural hospital yielded five and 10 year survival rates of 64% and 41%. These figures compare favorably with those obtained by standard treatment series.

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On the advantages of long delayed films after retrograde pyelography

By Stephen N. Rous, MD
Mark Harrold, MD
East Lansing

As the diagnostic excellence of excretory urography continues to improve, there are fewer indications for retrograde pyelography. For those genuine indications, the usual procedure involves the injection films and then a 20- or 30- minute delayed film. The purpose of this paper is to illustrate the virtue of a long (the next day) delayed film following the retrograde injection to achieve diagnostic accuracy.

Case Report

T.S. (#511-150-87) was a four and a half year old white male who was admitted on November 28, 1972, with a one day history of severe left-sided abdominal and CVA pain associated with vomiting. The child was somewhat dehydrated and was in acute distress from the pain. Admitting blood pressure verified on numerous occasions was 120/90. Temperature was 100 degrees rectally. The child was mildly acidotic with a CO_2 of 21 m/Eq/L; electrolytes were otherwise normal. Routine urine analysis disclosed 10 to 15 RBC's/HPF and some acetone but was otherwise unremarkable. Follow-up urine analyses were all within normal limits, and urine cultures were consistently negative. White count was 18,000 with a shift to the left.

Admitting diagnosis was acute intussusception, but a stat barium enema was normal. Because of the microhematuria, an excretory urogram was done which disclosed a normal right kidney and a dense left nephrogram seen at the end of four hours **(Fig. 1)**.

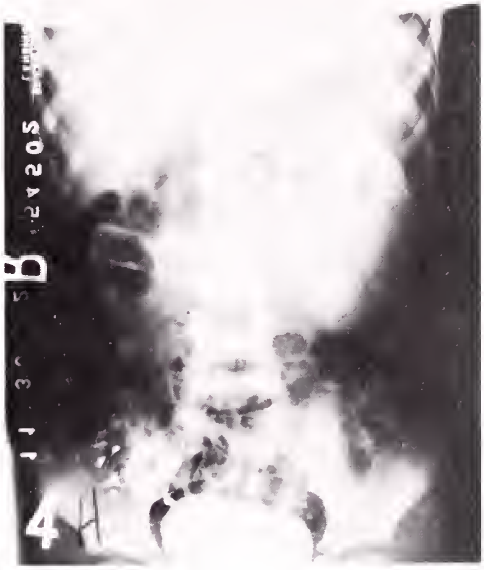

Fig 1 Excretory Urogram. Dense nephrogram on the left, four hours after injection

Cystoscopy and left retrograde pyelography were carried out under general anesthesia. The bladder, urethra and both ureteral orifices were normal. A #4 whistle tip catheter could be introduced about one cm. into the left ureter at which time a firm obstruction was met. Injection of contrast media through the catheter was difficult but did fill a cystic area that was clearly delineated **(Figs. 2 and 3)**. Most of the media came back into the bladder around the catheter. Rectal exam, which was not satisfactory when the child was awake, revealed a large cystic mass behind the bladder.

A flat plate was taken the following morning prior to a proposed renal angiogram (which was then cancelled), and it revealed that the contrast medium injected the previous night into the "cystic mass" had run up in a cephalad direction outlining a very dilated and tortuous ureter **(Fig. 4)**. Another film 24 hours later disclosed filling of the entire left collecting system showing a massive left hydroureteronephrosis **(Fig. 5)**.

The left kidney was explored with a provisional diagnosis of hydroureteronephrosis secondary to a congenital stricture at the distal ureter. After aspiration of the collecting system at surgery, the upper and lower thirds of the kidney collapsed completely. Some cortex was palpable in the middle third, but it was felt that this would not contribute significantly to total renal function, and its presence would prevent a maximal compensatory hypertrophy of the contralateral kidney. The left kidney and entire ureter were removed. Convalescence was uneventful, and the child was discharged on the sixth postoperative day. Blood pressure one month postoperative was 98/60.

Doctor Rous is Chief, Division of Urology and Professor of Surgery in the College of Human Medicine, Michigan State University. Doctor Harrold is Assistant Clinical Professor of Surgery (urology).

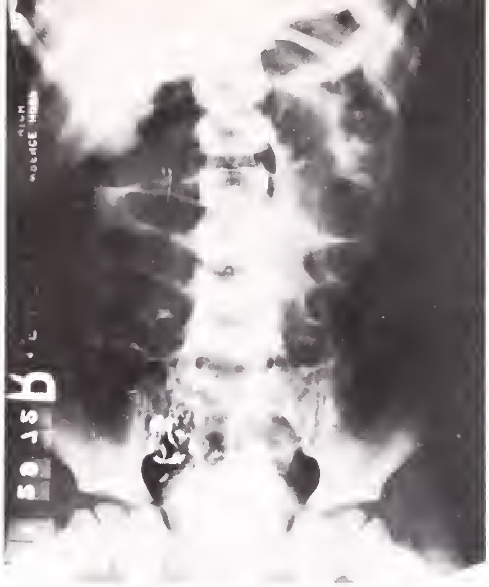

Fig 2. Left retrograde injection showing small piece of distal left ureter and large "cystic" mass.

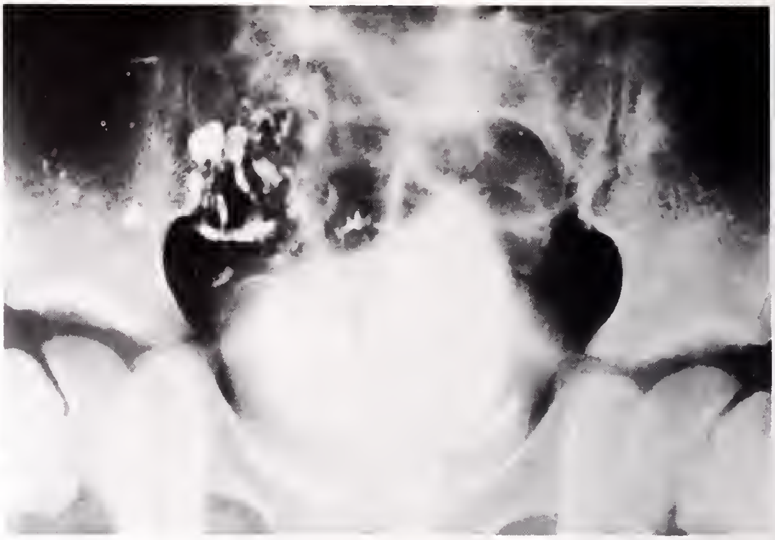

Fig. 3 Close-up of Figure 2.

Discussion

The initial retrograde studies **(Figures 2 & 3)** suggested a cystic mass that had to communicate with the ureter inasmuch as it was visualized following injection of contrast medium into the ureteral orifice, and the distal one cm. of ureter was clearly seen. A 10-minute delayed film with the patient in Trendelenberg position added nothing further. Review of the literature had one reported case in which the distal ureter did communicate with the seminal vesicle.[1] The possibility of a seminal vesicle cyst communicating with the distal ureter was, therefore, considered, and it was postulated that perhaps this large cyst was impinging upon the distal ureter, thereby obstructing the left kidney. Cysts of the seminal vesicle are normally associated with agenesis or hypoplasia of the ipsalateral kidney,[2] but they have been reported in conjunction with hydronephrosis[3] and polycystic disease[4] of the ipsalateral kidney as well as with a normal ipsalateral kidney.[5] In view of the sudden onset of extreme abdominal pain, hemorrhage into this non-functioning kidney was additionally considered, and an arteriogram was planned the day after cystoscopy. The flat plate at that time revealed the true diagnosis which was a massively dilated ureter terminating in a distal stricture **(Fig. 4)**. In the 8-12 hours following cystoscopy, the child apparently moved around sufficiently to allow the large amount of constrast medium which had pooled in the distal dilated ureter to run in a cephalad direction and outline the entire ureter. The "cystic mass" turned out to be a dilated ureter. Twenty-four hours later an additional flat plate showed that the constrast medium had filled all of the renal collecting system revealing a massive hydroureteronephrosis **(Fig. 5)**. The pathology was a congenital stricture of the distal two centimeters of ureter which was just barely patent until an apparent twisting of the tortuous, dilated ureter completely occluded the lumen and precipitated the severe pain. The correct diagnosis in this case would have been completely missed radiologically were it not for the delayed film that was taken 12 hours after a seemingly diagnostic retrograde study.

During the first few hours after cystoscopy, the child voided all of the contrast medium that was in his bladder and so the additional filling of the ureter and collecting system of the kidney did not represent vesico-ureteral reflux of contrast medium but represented a cephalad flow of contrast medium that was trapped in the distal ureter. The child had no vesico-ureteral reflux.

Further questioning of the mother following cystoscopy disclosed that for approximately six months prior to the acute episode the child had vomited about once a week, had complained of vague abdominal pains and on one occasion even spiked a temperature of 105 degrees which responded to antibiotic therapy.

Summary

The case of a four and a half year old boy with a distal left ureteral stricture has been reported. In this case, cystoscopy and retrograde studies suggested a large cyst of the seminal vesicle occluding the lower ureter and causing a nonfunctioning kidney. A flat plate of the abdomen the following day revealed the true diagnosis; contrast medium which had been trapped in what appeared to be a seminal vesicle was seen to diffuse in a cephalad direction outlining a massively dilated hydroureteronephrosis. The suggestion is advanced that in some cases the use of long delayed films following retrograde studies may be extremely advantageous.

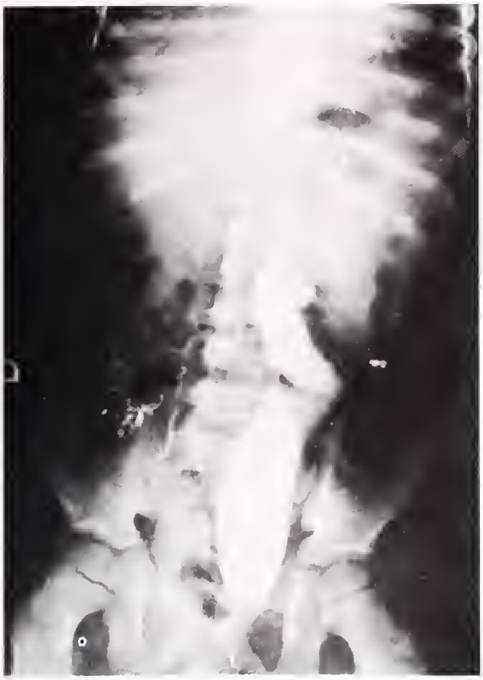

Fig 4 Film taken day after left retrograde injection showing dilated, tortuous left ureter

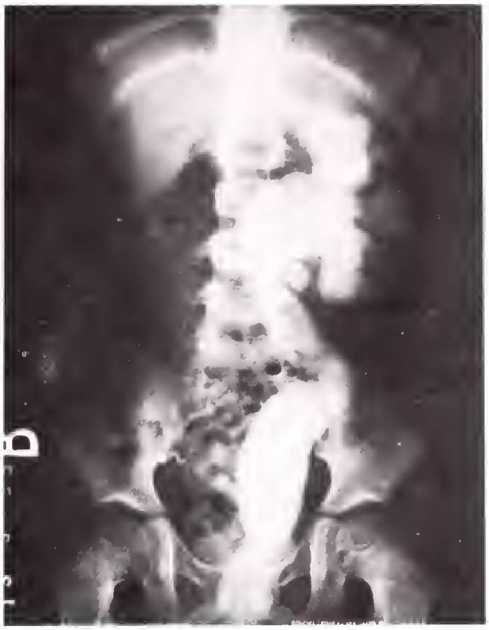

Fig 5 Film taken two days after left retrograde injection showing massive left hydroureteronephrosis

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The following case from the files of the Wayne County Medical Society Perinatal Mortality Study Committee is presented as an aid in continuing education.

Perinatal tips

By Paul M. Zavell, MD
Detroit

Maternal

The mother was a 22 year old Gravida I, Para O, blood group A+ Negro female who presented with preeclampsia, hydramnios, and premature rupture of the membranes at about 32 weeks gestation.

Serology was nonreactive. Labor was poor and, therefore, Pitocin was used to stimulate contractions. First stage of labor was 12 hours, second stage was 15 minutes, and third stage was 16 minutes. Seventy-five milligrams of Demerol were given approximately two and a half hours before actual delivery.

Twin "A" presented spontaneously in a cephalic presentation weight of 1,320 grams. Apgar at one minute was seven and at five minutes was nine. She was suctioned and given some environmental oxygen and appeared to do well. The second infant was born by breech, weighed 1,300 grams, was also a female, and required resuscitation by positive pressure with an apgar of four going to eight.

Both infants were in good condition when they left the delivery room. Infant "B" had a completely uncomplicated course.

Fetal

Twin "A" was placed in an isolette, an umbilical venous catheter placed and the baby was kept NPO. Estimated gestational age by physical characteristics was 31 weeks. Blood sugar one hour after birth and before the catheter was placed was between 45 and 90 mgs. Hematocrit was 71. Physical exam was essentially negative.

At age 14 hours, the baby had a brief apneic spell and was resuscitated by bagging with oxygen. At that time two cc. of sodium bicarbonate were given via the umbilical catheter. Normal respirations and heart rate were re-established by two minutes.

Two hours later the baby had another apneic spell and again, was quickly bagged and easily resuscitated.

At this point x-rays of the chest and abdomen were taken. It was noticed on x-ray that the gastric bubble was quite large and there was no gas past the duodenum. This was interpreted as over distention of the stomach due to bagging during the resuscitations and the NG tube was inserted to decompress the stomach.

However, repeat abdominal x-rays two hours later again showed the distended abdomen with what appeared to be a double bubble sign. A surgical consultant was obtained and he reviewed all the x-rays. In the meantime, the baby had passed meconium.

At age 36 hours, the baby had a distended abdomen and a large amount of excess oral secretions. Repeat x-rays showed no gas beyond the duodenum in spite of the fact that an NG tube was inserted and a mucus-like fluid was being aspirated. Repeat chest x-rays at 36 hours showed bilateral infiltrates in both lobes of the lungs. At this time a diagnosis of duodenal atresia was considered and the child was prepared for surgery the following morning.

The next morning, at age 56 hours, repeat chest and abdominal x-rays showed the abdomen to be unchanged. However, at this time a round hyperlucent area was discovered in the area of the upper mediastinum and the child was immediately taken to surgery.

At surgery a tracheo-esophageal fistula was discovered with the esophagus ending in a blind pouch and the fistula attached to the right mainstem bronchus. The fistula was divided and the pouch marsupialized. A gastrostomy tube was placed in the stomach. The infant tolerated the procedure exceptionally well; was taken back to the nursery and begun on hyperalimentation. She was continued on this for two weeks along with a course of penicillin and Kanamycin. She tolerated this exceptionally well; and was alert and active.

At age two weeks she again underwent a second surgical procedure at which time she was found to have an anular pancreas. A duodenostomy was performed and the child subsequently did extremely well being fed with hyperalimentation for one more month with regular routine milk feedings via the gastrostomy tube. She gained weight rapidly and at four months old, weighed 8½ lbs., was being fed baby food plus formula through the gastrostomy tube every three hours. A small VSD was discovered at age three months.

Developmentally she smiles, makes sounds and is beginning to reach for things.

Perinatal Committee Comments

1. Pregnancy complicated by pre-eclampsia should alert the attending physician to possible problems with the infant, especially respiratory distress.
2. Statistically obstruction of the G.I. Tract in the newborn is fairly more common when hydramnios occurs than in a normal pregnancy. The anular pancreas here is a good example.
3. Although infection did not occur here prolonged rupture of membranes should alert the doctor to this possibility *especially* in a premature infant.
4. Although in obstruction of the small intestine vomiting is a usual symptom and failure of air to pass through the small intestine is a sign, this case shows that both do not have to occur together in a particular case.
5. The finding of a normal chest x-ray and shortly thereafter aspiration in one or more lobes, and the finding of excessive large oral secretions should alert one to the possiblity of a Tracheal-Esophageal-Fistula being present.
6. The Committee does not recommend "routine use" of $NaHCO_3$ in an infant with "respiratory distress." Careful diagnostic studies including blood gases and chest x-ray are first recommended.
7. Other diagnoses that could have been considered here were diaphragmetic hernia, sepsis and rupture viscus.

Doctor Zavell is chairman, Neo-Natal and Hospital Care Commitee, Michigan Chapter, A.A.P., and chairman, Perinatal Mortality Study Committee, Wayne County Medical Society.

The use of deep hypothermia with complete circulatory arrest in the repair of complex congenital anomalies in infants

By Douglas M. Behrendt, MD
Herbert Sloan, MD
Ann Arbor

Hypothermia was employed to permit operations within the heart in the early days of cardiac surgery, prior to the introduction of satisfactory techniques of cardiopulmonary bypass. The relatively short period of time afforded by hypothermia alone resulted in this technique being largely supplanted by standard techniques of cardiopulmonary bypass for most cardiac surgical problems. Although several workers have continued to use deep hypothermia with circulatory arrest as an adjunct to cardiopulmonary bypass, interest in these techniques has not been widespread until recently. However, Okamoto,[1] Barratt-Boyes et al,[2] and Dillard et al[3] have reported excellent results of open heart surgery performed on infants utilizing different techniques of deep hypothermia with total circulatory arrest. These techniques provide ideal operating conditions within the heart and make possible the total correction of complex congenital anomalies in very small infants.

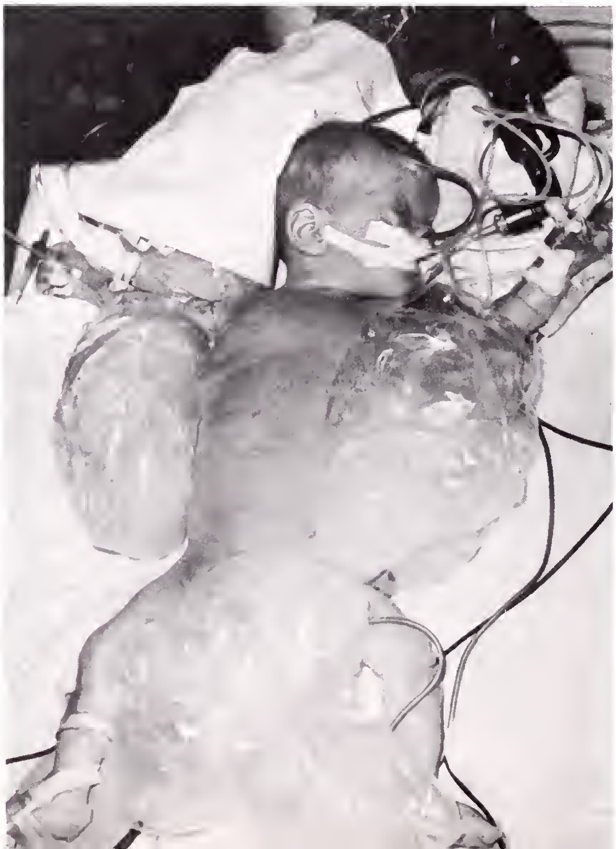
At the University of Michigan we have recently employed deep hypothermia and circulatory arrest during the correction of complex cardiac anomalies in five infants.

Technique

The infant is anesthetized and intubated. A balanced anesthetic technique is used consisting of morphine, curare, and nitrous oxide which does not depress the myocardium, yet promotes peripheral tissue perfusion. The pCO_2 is carefully monitored and kept in the normal range to maintain cerebral perfusion.

Crushed ice is packed about the trunk and head of the child, and surface cooling is carried out until the nasopharyngeal temperature reaches 28° Centigrade (**Figure 1**). The chest is then sterilized, and a median sternotomy is performed. A venous cannula is placed in the right atrium while an arterial cannula is placed in the arch of the aorta. The systemic ventricle is vented. Bypass is commenced at a perfusion rate of 100 ml/kg and the patient is rapidly cooled to 20° Centigrade. The perfusate contains fresh, heparinized blood mildly diluted with Ringer's lactate and passed through either a Pall or a Swank filter. The perfusion system consists of a standard Sarns roller pump with a Bentley infant oxygenator. After cooling, the perfusion is suspended, the perfusion lines are clamped, and the intracardiac repair is performed in a quiet, bloodless field. At 20 minute intervals perfusion is resumed for five minutes if prolonged periods of time are required. If this is the case the venae canvae must be separately cannulated. Upon comple-

Fig 1 An infant undergoing surface cooling with ice bags and a hypothermia mattress prior to an intracardiac correction



Doctor Sloan is professor and head, and Doctor Behrendt is assistant professor of surgery, Section of Thoracic Surgery, the University of Michigan Medical Center, Ann Arbor.

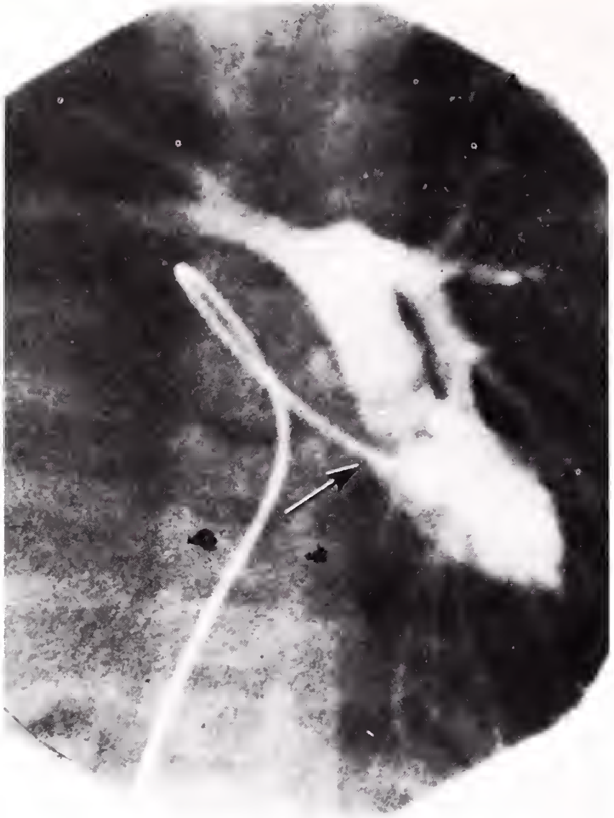


Fig. 2. Left ventriculogram from an infant with transposition of the great vessels and subpulmonic stenosis (Case Two). The obstructing membrane is clearly evident (arrow) beneath the pulmonary valve.

tion of the cardiac repair, perfusion is again resumed and the patient is rewarmed for the next 30 minutes to 34 Centigrade. During the rewarming phase the heart, which had ceased beating, resumes a normal beat, and it gradually takes over the circulation from the pump. Defibrillation has not been required. A mild metabolic acidosis has been observed during rewarming and in some patients a small dose of sodium bicarbonate has been required. No doubt this is due to the metabolic debt built up during the arrest period.

Case Reports

Case One. M.A. (U.M.H. 1 256 635) was a four week old infant girl weighing 2.8 kg. Evaluation revealed a ventricular septal defect, an atrial septal defect, a large patent ductus, and complete interruption of the aorta just distal to the left subclavian artery. She was in profound congestive failure with pneumonia, respiratory failure requiring intubation, and renal failure after several weeks of unsuccessful medical therapy.

A left thoracotomy was performed as surface cooling was started. The patent ductus was divided, the atretic segment of aorta was excised, and the ends anastomosed by direct suture. The thoracotomy incision was rapidly closed, and the patient was repositioned in the supine position. The nasopharyngeal temperature had reached 28° Centigrade by the time a median sternotomy was performed. Perfusion was instituted, and when the temperature reached 20° Centigrade the pump was turned off. During the next forty minutes the atrial and ventricular septal defects were closed. After rewarming, bypass was discontinued without difficulty. Even though she had a prolonged and difficult postoperative course, she was satisfactorily weaned from the respirator and extubated. The neurological status at the time of her discharge appeared to be normal for her age, and she has continued to do very well at home.

Case two M.H. (U.M.H. 1 249 231) was an infant boy with transposition of the great vessels. At 18 hours of age he underwent an emergency Blalock-Hanlon atrial septectomy. Preoperatively his pO_2 was 19 and his pH 6.9; he was flaccid and unresponsive with generalized edema, hypoglycemia, and hypokalemia.

These problems were gradually overcome after operation and he recovered neurologically. However, he could not be weaned from the respirator. Cardiac catheterization revealed severe subvalvular pulmonary stenosis **(Figure 2)** in addition to transposition of the great vessels. At age six months, weighing 6.2 kg., he was operated upon using the technique of hypothermia as described. The subpulmonary obstruction was resected, and an intra-atrial baffle was inserted **(Figure 3)**. The periods of circulatory arrest totalled 53 minutes.

The postoperative course was entirely uneventful. The baby was weaned from the ventilator on the third postoperative day, extubated on the 14th day, and was able to go home the following week. He remains completely well three months later.

Case Three. W.C. (U.M.H. 1 256 632) underwent balloon atrial septostomy at age seven days because of transposition of the great vessels. In spite of an initial improvement in oxygenation, cyanosis became intense by age five months (5.0 kg). Cardiac catheterization revealed no additional defects.

Complete correction by the Mustard technique was carried out using deep hypothermia with 41 minutes of total circulatory arrest **(Figure 4)**. There were no operative or postoperative complications, and he remains entirely well at home two months later.

Case Four. B.D. (U.M.H. 1 263 114) was a six week old baby girl weighing 3.0 kg. She was operated upon because of intractable cardiac failure due to a ventricular septal defect. She had multiple severe anomalies in other organ systems and had required tracheostomy for respiratory failure and pneumonia.

Using the deep hypothermia technique, the ventricular septal defect was closed with a patch dur-

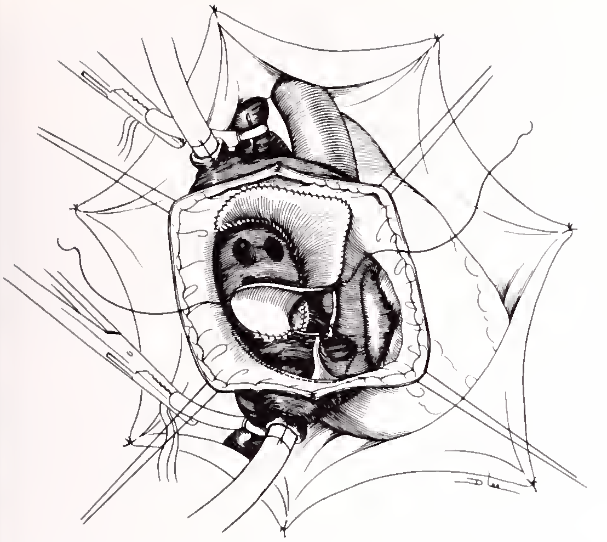


Fig. 3. This depicts the insertion of a pericardial baffle to redirect the venous flow within the atria (Mustard operation). Upon completion of the suture line, the pulmonary venous flow is directed to the tricuspid valve and the caval flow to the mitral valve.

ing 45 minutes of total circulatory arrest. After the repair she could not maintain an adequate cardiac output and she died. We have no specific explanation for this, other than her poor preoperative condition.

Case Five. B.M. (U.M.H. 1 273 178) was a three and one half month old infant girl weighing 4.0 kg. She was in right venticular failure because of pulmonary valve and infundibular hypoplasia with an intact ventricular septum and right-to-left shunting through the foramen ovale.

At operation, the infundibular obstruction was resected, and the pulmonary valve was opened. Twenty minutes of complete circulatory arrest were utilized. Her postoperative course was uncomplicated, and she is doing well at home.

Discussion

The majority of infants born with a congential heart disease die by the age of six months unless they are appropriately and aggressively treated. Previously, a number of palliative procedures have been used in many of these infants to allow them to reach an age when a total correction could be undertaken. We have always believed this to be less desirable than a one-stage correction carried out during infancy. It has been our practice for many years to close ventricular septal defects directly in order to avoid the additional morbidity of a preliminary banding.[4] The technique of deep hypothermia with complete circulatory arrest has now made possible totally corrective procedures in even younger infants and in even more complex situations. We have been impressed with both the simplicity and the ease of the technique used in

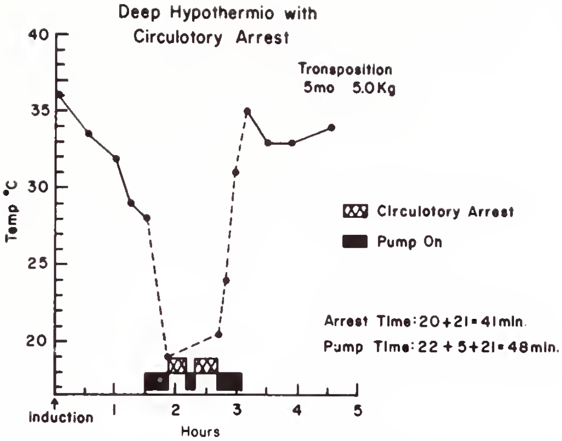


Fig 4. A plot of the esophageal temperature during the course of operation for transposition of the great vessels (Case Three).

these five infants and we intend to cautiously extend its use more widely in the future.

Several questions remain to be answered by further experience. The most serious question is whether there will be long-term neurological sequelae after prolonged periods of complete circulatory arrest even at temperatures as low as 20° Centigrade. Our first patient did have major transient neurological problems. Unfortunately she was in such a severe metabolic imbalance as a result of preoperative renal shutdown and an intraoperative error in bicarbonate dosage that no conclusions could be drawn as to the effect of the technique on her neurological function. The extremely smooth and entirely uncomplicated course of our other surviving patients encourages us to believe that neurological sequelae will not be a problem. This has been the experience of others[1,2,3] although it must be recognized that the period of postoperative follow-up is still short in all patients.

Another question to be answered is whether a one-stage early total correction will result in a better ultimate outcome than a two-stage approach, employing an initial palliative operation followed by a total correction later in childhood. Palliative operations have carried substantial mortality rates when performed upon sick infants, in the range of 20 percent for atrial septectomy, pulmonary artery banding, and systemic-pulmonary shunting.[5,6,7] To these losses must be added the losses sustained at the time of eventual complete correction. It would seem reasonable that a higher ultimate salvage rate could be achieved with a one-stage approach. Also, the parents and the child would be spared the psychological problems resulting from protracted illness. Only further experience will prove whether or not this is in fact true.

TABLE I
INFANTS WHO HAVE UNDERGONE OPERATION

patient	age (months)	weight (kg)	diagnosis	results
M A	1	2 8	VSD, ASD, aortic interruption, PDA	survived
M H	6	6 2	TGA, subpulmonary stenosis	survived
W C	4	5 0	TGA	survived
B D	1½	3 0	VSD, ASD	died
B M	3½	4 0	pulmonary atresia	survived

KEY	VSD	ventricular septal defect
	ASD	atrial septal defect
	PDA	patent ductus arteriosus
	TGA	transposition of the great arteries

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MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

MONTHLY SURVEILLANCE REPORT

CASES OF CERTAIN DISEASES
REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH
For the four-week period ending April 27, 1973

	1973 This 4-Week Period	1972 Same 4-Week Period	1973 Total To Above Date	1972 Total Same Date	Total Cases for 1972
Rubella	378	192	913	775	1,460
Congenital Rubella Syndrome	0	0	1	0	1
Measles	1,037	329	2,276	1,039	2,353
Whooping Cough	4	5	29	40	116
Diphtheria	0	1	0	1	1
Mumps	793	425	2,604	1,726	3,729
Scarlet Fever & Strep Sore Throat	2,504	1,110	9,585	5,396	13,304
Tetanus	0	0	0	0	2
Poliomyelitis (paralytic)	0	0	0	0	1
Hepatitis	314	300	1,313	1,553	4,322
Salmonellosis (other than S typhi)	46	53	198	226	781
Typhoid Fever (S typhi)	0	2	3	3	7
Shigellosis	42	34	171	169	574
Aseptic Meningitis	18	3	48	23	266
Encephalitis	10	5	44	25	108
Meningococcic Meningitis	7	5	18	20	55
H. Influenza Meningitis	12	7	38	27	81
Tuberculosis	162	151	437	563	1,609
Syphilis	318	364	1,460	1,666	4,815
Gonorrhea	2,043	1,674	9,259	7,073	24,728

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, MD, Director
Michigan Department of Public Health

Host of Michigan MDs to participate in AMA convention

A number of Michigan physicians will take parts in the 122nd Annual Convention of the AMA June 23-28 in New york City. The convention, with a "Confluence '73" theme, will provide 18 postgraduate courses for physicians attending, 10 more than in 1972.

Michigan doctors holding positions of highest responsibility during the AMA House of Delegates meeting will include John J. Coury, MD, Port Huron, MSMS president, who will serve as chairman of the AMA Reference Committee on Medical Education. Serving on the Reference Committee on Legislation will be James C. Danforth, MD, Grosse Pointe Woods.

As the scientific meetings get underway, presentations will be made by Joseph A. Rinaldo, Jr., MD, Detroit, on the Anatomy and Physiology of the Esophagus; C. Mark Vasu, MD, Grand Rapids, cardiopulmonary resuscitation; Paul R. Dumke, MD, Detroit, business meeting, Section on Anesthesiology; Norman D. Nigro, MD, Detroit, Inflammatory Diseases of the Anus and Rectum; E. Richard Harrell, MD, Ann Arbor, business meeting, Section on Dermatology; Thomas K. Burnham, MD, and Paula W. Bank, Detroit, Antinuclear Antibodies.

Further parts will be taken by John R. Kirkpatrick, MD, and Robert F. Wilson, MD, Detroit, during the session on the Significance of Cardiac Arrhythmias in the Septic Patient; Peter Lynch, MD, Ann Arbor, Inflammatory Vulvar Lesions including Viral Infections; Harold F. Falls, MD, Ann Arbor, two discussions of the Section on Ophthalmology; J. Copner Webster, MD, Oak Park, Ototoxicity; Michael E. Johns, MD, John G. Batsakis, MD and Charles D. Short, MD, Ann Arbor, Oncocytomas and Oncocytoid Tumors of the Salivary Glands; Sherman Jay Silver, MD, and Richard Malvin, PhD, Ann Arbor, the Physiology of Compensatory Renal Hypertrophy and William R. Olsen, MD, Ann Arbor, Peritoneal Lavage in Blunt Abdominal Trauma.

Participating in the scientific exhibits of the various sections will be Franklin V. Wade, MD, Flint, special exhibit on fractures; E. K. Zsigmond, MD, Akitomo Matsuki, MD, and S. P. Kothary, Ann Arbor, anesthesiology; H. M. Allen, MD, M. A. Block, MD, and B. M. Schuman, MD, Detroit, general surgery; Stuart W. Hamburger, MD, and Eduardo Phillips, MD, Detroit, general surgery; J. M. Miller, M. D., Saeed Uz Zafar, MD, and James Karo, MD, Detroit, internal medicine; Robert S. Knighton, MD, R. Boulos, MD, and F. A. Achecar, MD, Detroit, neurological surgery; Asghar Afsari, MD, Detroit, ob-gyn; Ronan O'Rahilly, MD, Detroit, otorhinolaryngology; Vergil N. Slee, MD, and Martin L. Waldman, MD, Ann Arbor, allied medicine.

Fuller participation of interns and residents in MSMS activities was the topic at a recent MSMS workshop for executives and leaders of county medical societies whose geographical areas include teaching hospitals. The five component societies represented only allow associate membership of interns and residents, without dues and without voting privileges, paralleling MSMS policy. The AMA, however, has urged full membership in state societies with active privileges and provides direct membership for residents who cannot become full members in the county or state of their residence.

1973 version: Maternal Health Conference

A capacity crown of over 700 physicians, nurses, and medical students filled the ballroom of the Olds Plaza Hotel, Lansing, for the 12th annual Michigan Conference on Maternal and Perinatal Health, sponsored by MSMS, other interested health organizations, and pharmaceutical houses.

Speakers at the 1973 conference concentrated on breech presentations, induction of labor and neonatal cardiopulmonary problems. Among them were, from left in left picture, Ronald L. Poland, MD, Detroit; Robert C. Borer, MD, Ann Arbor, and in right picture, Joseph J. Woods, MD, Detroit, then president, Michigan Society of Obstetrics and Gynecology.

Babies are what it's all about, and just to prove it, this little infant came to the conference, to the delight of Miss Helen Schulte, chief, MSMS Division of Scientific Affairs. The baby was brought by its mother, a conferee.

A high point of the conference came when reporters gathered to hear MSMS spokesmen announce the Maternal Health Committee's recommendations on state abortion regulations. The news conference was presided over by Joseph L. Sheets, MD, center, chairman of the Maternal Health Conference, and Richard Mellis, MD, right, Maternal Health Committee chairman. On hand to answer questions about the state's abortion guidelines was Maurice S. Reizen, MD, left, director, Michigan Department of Public Health.

MSMS, and Ingham medical assistants talk telephones

Thirty Ingham County medical assistants sharpened their telephone manners April 3 at the first in a series of workshops presented at MSMS headquarters. Thomas Payne, MD, Lansing, chairman, MSMS Public Relations Committee, led the lively discussion of the proceedings, which followed a dinner of chicken cacciatore and wine.

"Doctor Jones' office . . . " began the series of simulated telephone conversations through which the medical assistants reviewed their own telephone techniques. The conversations were enacted by Mrs. Sherry Decker, center and Mrs. Sherry Hall, right, and introduced by Mrs. Jeanne Smith, left, all of the MSMS staff.

Reactions to the "good" and "bad" telephone conversations were expressed by a panel of experts, among them Mrs. Dorothy Brandis, chairman, Promotion Committee, Michigan Branch, AAMA. Robert Stow, MD, Lansing, MSMS Councilor, and Mrs. Audrie Chute, left, president, State of Michigan Branch, American Association of Medical Assistants.

Medical assistants society helps physician upgrade his practice

Mrs. Chute

By Audrie W. Chute, CMA
President, Michigan Branch, AAMA

Doctor, are you demanding top-notch performance from your office personnel? Are you asking for continual upgrading of standards? Do you suggest in-service training and educational classes? Do you want to see your staff develop to the full potential of performance of assigned responsibilities?

A suggestion toward attaining the attributes of a well run office is membership for your medical assistants in the American Association of Medical Assistants.

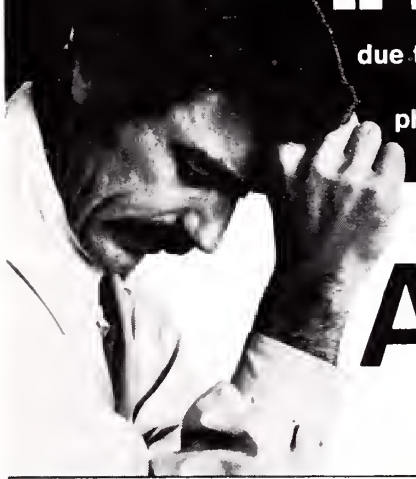
Membership [open to anyone "who is employed by, or supervised by, a physician who (1) holds an unrestricted license to practice medicine and/or surgery, and/or (2) who is eligible for membership in a component society of the American Medical Association"] in the local county medical assistants society provides the opportunity to develop the full potential of medical assistants.

Too few doctors are aware of the endorsement by the AMA's House of Delegates of the organization of medical assistants—the AAMA. They have the conception of a social club or worse, a trade union.

It remains a problem of communication between the doctors and the profession of medical assisting as to the benefits to the doctor and the medical assistant of membership. The educational aims of the AAMA are toward the development of technical proficiency and administration plus friendly ambassadorship in the office.

Charles Hoffman, M.D., president of the American Medical Association, in addressing the AAMA convention in Phoenix, stated, "Physicians across the country could spread *their* skills more effectively if they would use *your* skills more fully. Widespread use of so-called 'physician's assistants,' or feldshers, may be a dream of some physicians, whereas your qualifications are real and proven."

For further information regarding membership for your medical assistants, contact Mrs. Kay Doane, State Membership Chairman, 310 Meadow Drive, Battle Creek, 49015.



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impotence
due to androgenic deficiency in the American male.
The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

NEW CLINICAL STUDY

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T. Jakobovits
Fertility and Sterility, January 197
Official Journal of the American Fertility Society

Android®
(thyroid-androgen) tablets

Double-Blind Study and Type of Patient: 100 patients suffering from impotence. the patients receiving the active medicat (Android) a favourable response was se in 78%. This compares with 40% placebo. Although psychotherapy is ir cated in patients suffering from functio impotence the concomitant role of cher therapy (Android) cannot be disputed.

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Each yellow tablet contains:
Methyl Testosterone . . 2.5 mg.
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Android-X
EXTRA HIGH POTENCY
Each orange tablet contains:
Methyl Testosterone . 12.5 mg.
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Glutamic Acid . . . . 50 mg.
Thiamine HCL . . . . 10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C
Each white tablet contains:
Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (¼ gr.) . . . 15 mg.
Ascorbic Acid (Vit. C) . 250 mg.
Thiamine HCL . . . . 25 mg.
Glutamic Acid . . . . 100 mg.
Pyridoxine HCL . . . . 5 mg.
Niacinamide . . . . 75 mg.
Calcium Pantothenate . 10 mg.
Vitamin B-12 . . . . 2.5 mcg.
Riboflavin . . . . 5 mg.
Dose: 2 tablets daily.
Available: Bottles of 60, 500.

Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardi disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occa cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl T terone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, heac dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected to and during thyroid administration

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, pa receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.

Hypercalcemia may occur, particularly in immobilized patients: use of Testosterone should be discon as soon as hypercalcemia is detected.

References: 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of impotence. Clin Med 12:69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltestos thyroid compound. West Med 5:67, 1964. 3. **Titaft, A. S.** Methyltestosterone-thyroid in treating imp Gen Prac 25:6, 1962. 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagha** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 1959. 5. **Farris, E. J., and Caltan, S. W.** Effects of L-thyroxine and liothyronine on spermatog J Urol 79:863, 1958. 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott delphia, 1955, p. 1432. 7. **Warshub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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ur skin—the human integument
-covers us, defines us, protects
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urns, abrasions. And infections.
eosporin Ointment fights
nfection by providing broad
ntibacterial action against sus-
eptible skin invaders. It contains
ntibiotics that are rarely used
ystemically, reducing the risk
f sensitization.

INDICATIONS: *Therapeutically,* used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

NEOSPORIN® Ointment

OLYMYXIN B-BACITRACIN-NEOMYCIN)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q.s. In tubes of 1 oz. and ½ oz. and 1/32 oz. (approx.) foil packets.

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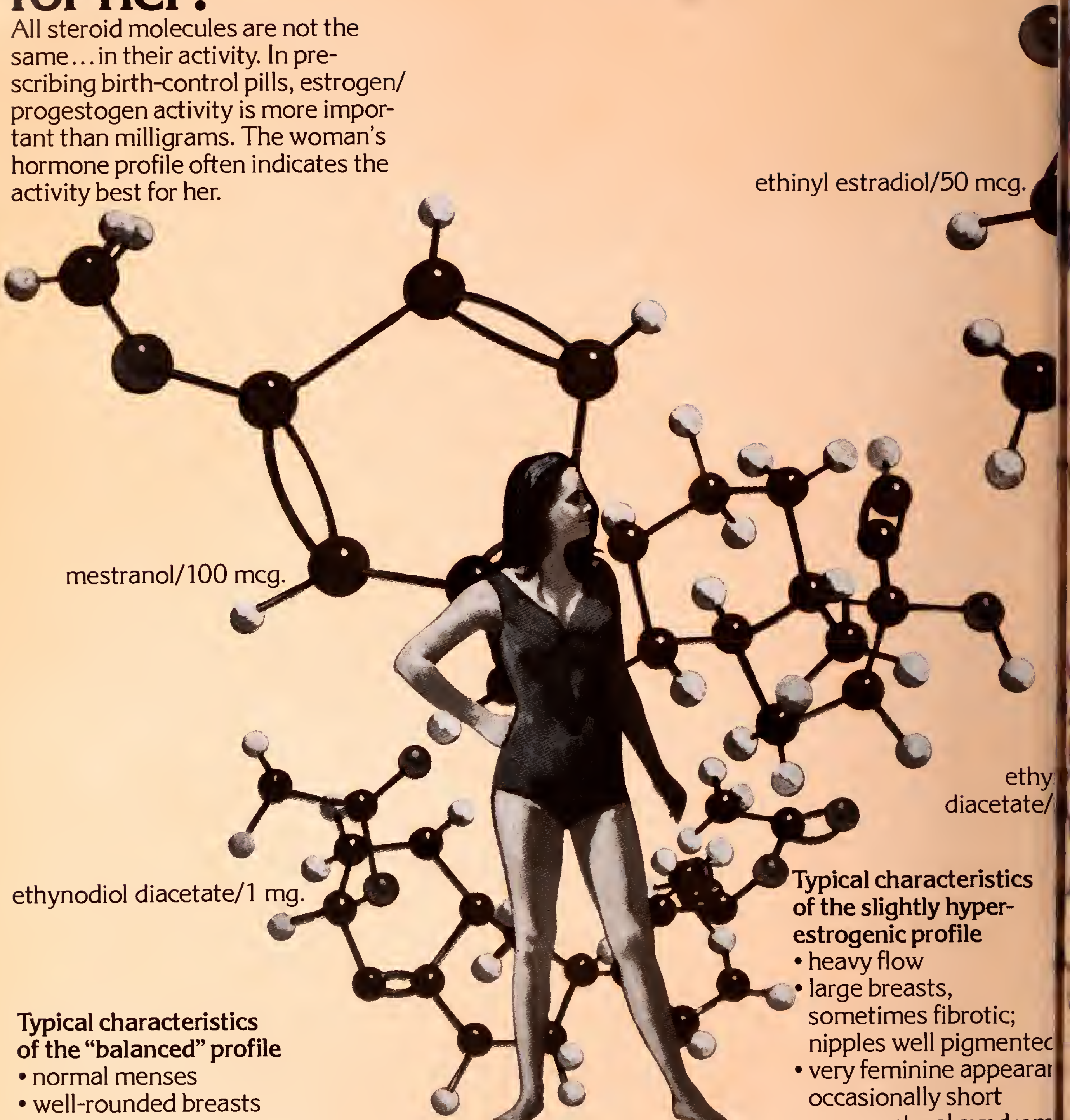
What's in it for her?

All steroid molecules are not the same… in their activity. In prescribing birth-control pills, estrogen/progestogen activity is more important than milligrams. The woman's hormone profile often indicates the activity best for her.



ethinyl estradiol/50 mcg.

mestranol/100 mcg.

ethynodiol diacetate/1 mg.

ethy

diacetate/

Typical characteristics of the "balanced" profile

- normal menses
- well-rounded breasts
- clear complexion
- normal figure with normal secondary sex characteristics
- normal cytohormonal pattern

This "center spectrum" pill has had excellent user acceptance for over seven years.

Ovulen®

Available in 20-, 21- and 28-pill schedules
Each white tablet contains: ethynodiol diacetate 1 mg./mestranol 0.1 mg.
Each pink tablet in Ovulen-28® is a placebo containing no active ingredients

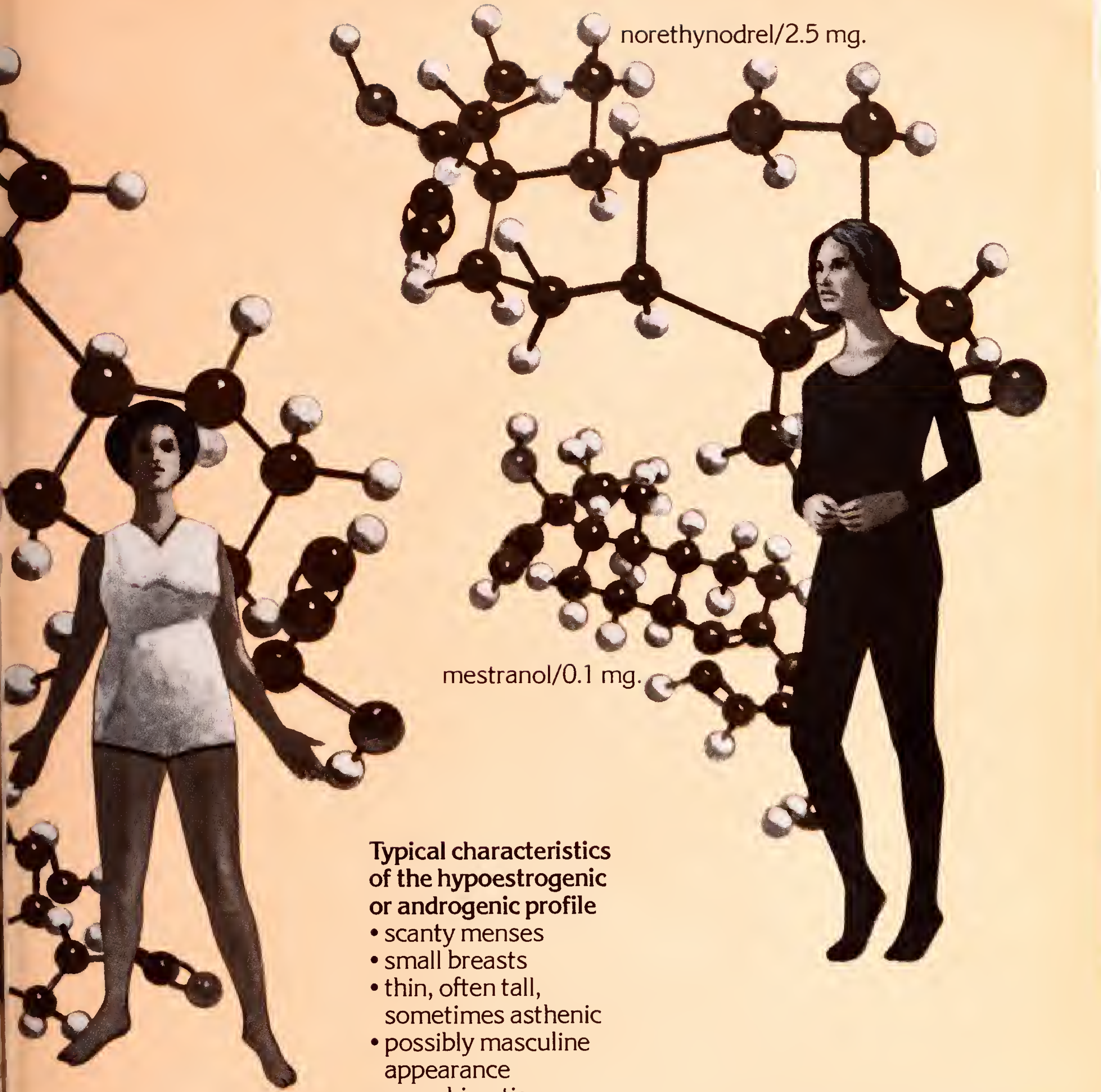
for the majority of women… when centrally balanced activity is preferred

Typical characteristics of the slightly hyper-estrogenic profile

- heavy flow
- large breasts, sometimes fibrotic; nipples well pigmentec
- very feminine appearar occasionally short
- premenstrual syndrom fluid retention
- tendency to uterine fibroids
- high pyknotic index

This formulation, which less estrogenic activity a a moderate progestoger dominance, may be a gc beginning.

For brief summary of prescribing information, please see next page.


norethynodrel/2.5 mg.
mestranol/0.1 mg.

Typical characteristics of the hypoestrogenic or androgenic profile

- scanty menses
- small breasts
- thin, often tall, sometimes asthenic
- possibly masculine appearance
- acne, hirsutism
- low sexual motivation
- thin vaginal lining, tendency to vaginitis and dyspareunia

This pill has a relatively weak and unique* progestogen with inherent estrogenicity. Clinically, just as in animal studies, it appears not to possess antiestrogenic and androgenic activity.

emulen®

ble in 21- and 28-pill schedules
white tablet contains: ethynodiol
tate 1 mg./ethinyl estradiol 50 mcg
pink tablet in Demulen-28® is a
bo containing no active ingredients.

suited to most women
n low estrogenic activity
moderate progestogen
inance are preferred

Enovid-E®

Available in 20- and 21-pill schedules
Each tablet contains: norethynodrel
2.5 mg./mestranol 0.1 mg.

a clear choice for women when estrogen dominance and no androgenic activity are preferred

*Of all the progestogens, norethynodrel most resembles the molecular structure of the estrogens. It has the weakest progestational activity of any progestogen in a combination pill.

Ovulen®

Each white tablet contains:
ethynodiol diacetate 1 mg./mestranol 0.1 mg.

Demulen®

Each white tablet contains:
ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg.

Each pink tablet in Ovulen-28® and Demulen-28® is a placebo, containing no active ingredients.

Actions—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations pre-existing uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible
influence of prolonged Ovulen or Demulen therapy on pituitary, ovaria
adrenal, hepatic or uterine function awaits further study. A decrease
glucose tolerance has been observed in a significant percentage
patients on oral contraceptives. The mechanism of this decrease
obscure. For this reason, diabetic patients should be carefully observ
while receiving Ovulen or Demulen therapy. The age of the patient co
stitutes no absolute limiting factor, although treatment with Ovulen
Demulen may mask the onset of the climacteric. The pathologist shou
be advised of Ovulen or Demulen therapy when relevant specime
are submitted. Susceptible women may experience an increase
blood pressure following administration of contraceptive steroids.

**Adverse reactions observed in patients receiving oral co
traceptives**—A statistically significant association has been dem
strated between use of oral contraceptives and the following seric
adverse reactions: thrombophlebitis, pulmonary embolism and ce
bral thrombosis.

Although available evidence is suggestive of an association, sucl
relationship has been neither confirmed nor refuted for the follow
serious adverse reactions: neuro-ocular lesions, e.g., retinal thro
bosis and optic neuritis.

The following adverse reactions are known to occur in patie
receiving oral contraceptives: nausea, vomiting, gastrointestinal syn
toms (such as abdominal cramps and bloating), breakthrough bleedi
spotting, change in menstrual flow, amenorrhea during and after tre
ment, edema, chloasma or melasma, breast changes (tenderne
enlargement and secretion), change in weight (increase or decrea
changes in cervical erosion and cervical secretions, suppression
lactation when given immediately post partum, cholestatic jaundi
migraine, rash (allergic), rise in blood pressure in susceptible individu
and mental depression.

Although the following adverse reactions have been reported
users of oral contraceptives, an association has been neither c
firmed nor refuted: anovulation post treatment, premenstrual-
syndrome, changes in libido, changes in appetite, cystitis-like syndro
headache, nervousness, dizziness, fatigue, backache, hirsutism, loss
scalp hair, erythema multiforme, erythema nodosum, hemorrha
eruption and itching.

The following laboratory results may be altered by the use of
contraceptives: hepatic function: increased sulfobromophthalein ret
tion and other tests; coagulation tests: increase in prothrombin, Fact
VII, VIII, IX and X; thyroid function: increase in PBI and butanol extr
able protein bound iodine, and decrease in T^3 uptake values; metyrap
test and pregnanediol determination.

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traception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*:2
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Further Report, Brit. Med. J. 2:651-657 (June 14) 1969. **4.** Sartv
P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thron
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Study, Amer. J. Epidem. 90:365-380 (Nov.) 1969.

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**with estrogen-
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Actions—Enovid-E acts to prevent ovulation by inhibiting the
put of gonadotropins from the pituitary gland. Enovid-E, depresses
output of both the follicle-stimulating hormone (FSH) and the lu
izing hormone (LH).

Indication—Enovid-E is indicated for oral contraception.

The *Special Note, Contraindications, Warnings, Precautions*
Adverse Reactions listed above for Ovulen and Demulen are applic
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Small doses

Dean C. Burns, MD, Petoskey,

is the recipient of the fifth annual Distinguished Citizen Award of the Lake Superior State College board of control. Doctor Burns received the college's highest citizen award for founding the Burns Clinic in Petoskey and for his leading role in establishment of North Central Michgian College in Petoskey.

Robert Chesky, MD, Ann Arbor,

is the recipient of a Distinguished Consumer Safety Award from the national Consumer Safety Glazing Committee, for his efforts in successfully promoting Michigan legislation now requiring safety glass in hazardous locations.

Robert D. Coye, MD, Detroit,

dean of the WSU School of Medicine, is a new member of the Michigan Cancer Foundation board of trustees.

Bertram Dinman, MD, Ann Arbor,

is new vice president of the American Academy of Occupational Medicine. He is director of the Institute of Environmental and Industrial Health in the U-M School of Public Health.

Elisha S. Gurdjian, MD, Detroit,

professor emeritus, has been honored by Wayne State University with the naming for him of the Gurdjian-Lissner Biomechanics Laboratory in the WSU Medical Research Building. Doctor Gurdjian, a pioneer of research into head injuries and head protection, was the recipient of the MSMS Certificate of Commendation in 1972.

Clifford E. Keeler, MD, Jackson,

is new president of the Jackson Area Drug Abuse Council. He also will serve as executive committee chairman, while Robert E. Medlar, MD, Jackson, president of the Jackson County Medical Society, will serve as medical consultant to the council.

Kenneth R. Magee, MD, Ann Arbor,

is one of four U.S. physicians whose comments on prevention and relief of migraine appear in the April 16 issue of *Modern Medicine.* He is professor of neurology at the U-M Medical Center.

Russell J. Paalman, MD, Grand Rapids,

is president-elect of the Central Association of Obstetricians and Gynecologists, and will take office as president in October. He is a senior attending physician in the Butterworth Hospital Department of Ob-Gyn.

Beverly C. Payne, MD, Ann Arbor,

is a governor-elect of the American College of Physicians. After an initial service of 12 months, Doctor Payne, assistant dean of the U-M Medical School, will become one of seven new governors of the college. Previous Michigan holders of the position are H. Marvin Pollard, MD, Ann Arbor, and Muir Clapper, MD, Detroit.

B.L. Pederson, MD, Bay City

was inducted into the Upper Peninsula Sports Hall of Fame in March ceremonies at Northern Michigan University, Marquette. Doctor Pederson was a member of the 1950 U-M Rose Bowl championship team and received the Yost Award for academic and athletic excellence in 1952 and 1953. Total membership in the UP Hall of Fame is 22.

Justin L. Sleight, MD, Lansing,

will take up residence July 15 in Bo, Sierra Leone, for one year. He will assist Lowell Gess, MD, at present the only ophthalmologist in the state of Sierra Leone, with a population of 2½ million. The two will care for patients at the Bo Eye Clinic.

Benjamin J. Stone, MD, East Lansing,

is a charter member of the board of the newly formed Central Region, Michigan TB and Respiratory Disease Association.

C. Mark Vasu, MD, Grand Rapids

received the annual Liberty Bell Award of the Grand Rapids Bar Association in ceremonies April 25. Doctor Vasu, a leader in improving emergency medical care in Kent County, was selected because his "outstanding public service . . . epitomizes the concept of individual responsibility under our Constitution."

Charles H. Wright, MD, Detroit,

is the author of an original hour-long Easter drama "Were You There?" The program was presented by the Central Educational TV Network April 18 on 25 public TV stations serving 15 states in the central U.S. The cast and technical staff all were from Detroit's black community. Doctor Wright was the recipient of an MSMS Certificate of Commendation during recent years.

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MARKER

T$_4$ IS THE PREDICTABLE HORMONE BECAUSE IT LOVES PROTEIN.

SYNTHROID® (sodium levothyroxine) is pure synthetic T$_4$, the major circulating thyroid hormone. It is reliable to use because of its affinity for protein-binding sites in the blood. T$_3$ is more fickle. Sometimes it binds. Sometimes it doesn't. T$_4$ more *predictably* binds to protein.

ALL THYROID-FUNCTION TESTS ARE USEFUL IN MONITORING SYNTHROID THERAPY

No calculations are needed, test interpretation is simple.

Any of the commonly used T$_4$ thyroid function tests (P.B.I., T$_4$ By Column, Murphy-Pattee, Free Thyroxine) are useful in monitoring patients on T$_4$ because they *all* measure T$_4$. Patients on SYNTHROID are thereby easy to monitor because their results will fall within predictable, elevated test ranges. Of course, clinical assessment is the best criterion of the thyroid status of the drug-treated patient.

TEST	HYPOTHYROID	SYNTHROID THERAPEUTIC NORMAL
P.B.I.	Less than 4 mcg %	6-10 mcg %
T$_4$ By Column	Less than 3 mcg %	7-9 mcg %
T$_3$ (Resin)	Less than 25%	27-35%
T$_3$ (Red Cell)	Less than 11%	11.5-18%
Free Thyroxine	Less than 0.7 nanograms %	0.7-2.5 nanograms %
Murphy-Pattee	Less than 2.9 mcg %	4-11 mcg %

TWO GOOD REASONS WHY THE ROAD TO NORMALIZED THYROID STATUS IS SO SMOOTH FOR THE SYNTHROID PATIENT.

(1) The onset of action of T$_4$ is gradual. It has a long in vivo "half-life" of over six days. (Occasional missed doses or accidental double-doses are of les concern because of this factor)^1; (2) since SYNTHROID contains on T$_4$, the potential for metabolic surges traceable to more potent iodides (T$_3$) is eliminated.

AS WITH ANY THYROID PREPARATION, CAUTIOUS OBSERVATION OF TH PATIENT DURING TH BEGINNING OF THERAPY WILL ALER THE PHYSICIAN TO ANY UNTOWARD EFFECTS.

Side effects, when they do occu are related to excessive dosage. Caution should be exercised in administering the drug to patient with cardiovascular disease. Rea the accompanying prescribing information for additional data write Flint Laboratories.

Choose the Smooth Road ...to thyroid replacement therapy

TIENTS CAN BE CCESSFULLY INTAINED ON A UG CONTAINING YROXINE ALONE.

roxine (T_4) is, as you know,
major circulating hormone
luced by the thyroid gland.
also produced, in smaller
unts, and is active at the
ılar level. For years it has been
rking hypothesis among
ocrinologists that T_4 is
verted by the body to T_3. In
this process, called
odination," was demonstrated
raverman, Ingbar, and Sterling[2].
oes convert to T_3, though the
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ied.
ıe conversion has been
cally demonstrated during the
nistration of T_4 to athyrotic
nts. Their thyroid status is
ıalized on SYNTHROID alone,
ıe presence of T_3 in these
nts has been clearly shown.

WHY DOES SYNTHROID COST LESS THAN SYNTHETIC DRUGS CONTAINING T_3?

Very simple. T_3 costs more to make synthetically than does T_4. So it is economically necessary for a synthetic thyroid medication containing T_3 to cost more than one containing T_4 alone. Synthetic combinations cost patients nearly 50% more than SYNTHROID[3] because the T_3 costs more to start with; also there is the additional expense of formulating a tablet containing two active ingredients.

1. Latiolais, C. J., and Berry, C. C.: Misuse of Prescription Medications by Outpatients, *Drug Intelligence & Clin. Pharm.* **3**:270-7, 1969.
2. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T4) to Triiodothyronine (T3) in Athyreotic Human Subjects, *J. Clin. Invest.* **49**:855-64, 1970.
3. American Druggist BLUEBOOK, March, 1971.

ynthroid®
odium levothyroxine)

E FACTS ARE EAR AND HERE OUR OFFER.

TS:
ıetic thyroid drugs are an
ovement over animal gland
ucts. Patients, even athyrotic
can be completely
tained on SYNTHROID (T_4)
. Thyroid function tests are
to interpret since they are
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nt adheres to SYNTHROID.
synthetic thyroid drugs,
HROID is the most
omical to the patient.

OFFER:
Free TAB-MINDER medication dispensers to start or convert all your hypothyroid patients to SYNTHROID. Free information to physicians on role of thyroid function tests in a new booklet titled: "Guideposts to Thyroid Therapy." Ask us.

Name

Address

City State Zip

Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) **Tablets** include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) **for Injection** is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose, preferably after breakfast. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) **for Injection** may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC
Morton Grove, Illinois 60053

Jackson County Medical Society conducts aggressive public information campaig

By Judith Marr
Managing Editor

"Gonorrhea Problem Grows in Michigan," reads the banner headline of a page one story in the Jackson *Citizen Patriot* of May 3, 1972.

The article drew much public attention with its premier spot in that day's paper. And it was only the first in a series of nearly 50 public service articles on medicine which have appeared in the newspaper to date, inaugurated by the Jackson County Medical Society.

In addition, two TV shows and several radio shows on medical subjects of public interest have been arranged by the medical society.

The articles, TV and radio shows draw heavily on the expertise of local physicians, quoting them extensively and passing on to the public the knowledge and advice of their own city's doctors.

The articles have explained the new medical examiner system, the effectiveness of "the pill," new rules on aspirin packaging, hay fever, contact lenses, safe cosmetics use, vasectomies, the importance of physical checkups, the hazards of hot weather, emergency room procedures, orthopedics and athletics, child abuse and the new family practice specialty.

In many cases, photos of the physicians interviewed or artists' conceptions of the subject have dressed up the articles and drawn reader attention.

Many additional short articles have announced board certifications of Jackson area physicians, the presentation of awards or completion of further study by the doctors, and opening of new practices by new physicians in town. The latter are part of the extensive county medical society efforts to attract new physicians.

The credit for this extensive public service effort belongs to Harold Oster, MD, 1972 JCMS president; Robert Medlar, MD, current JCMS president, Robert B. Swartley, part-time executi director of the society, and Frank Korotney, MI Public Service Committee chairman.

James S. Imboden, AMA field service rep for th region including Michigan, wrote the director the AMA Communications Division to describ "this truly outstanding press relations program b a county medical society.

"What has been done here should in some way b called to the attention of all counties because th public relations for medicine is the finest I've ev seen anywhere," wrote Mr. Imboden.

"Our main job is to provide a service for our com munity," says Mr. Swartley. "The articles help th doctors, yes, but the people also are thankful f the information and they know that there are do tors to take care of them."

Mr. Swartley initially approached the *Citiz Patriot* with the society's blessing and its offer aid the newspaper in any way possible to get a curate and complete medical information to th people.

The series of articles is the result, with th emphasis on local physicians.

Mr. Swartley emphasizes that the Jacks physicians are pleased with the articles. As ma as possible of the society's members have be featured, a different one each time.

"The nice thing is, it's easy for the doctor," adds.

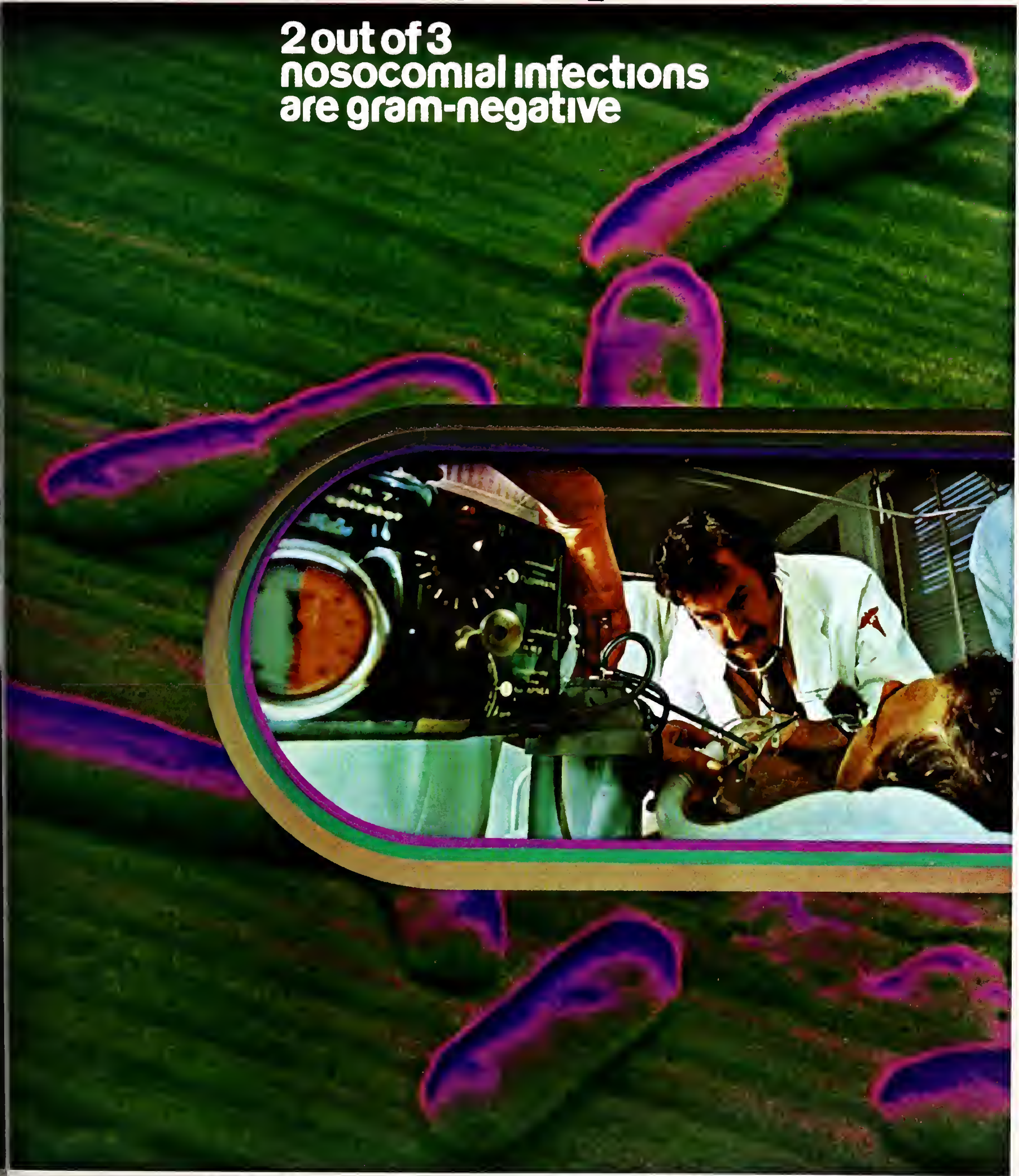
Mr. Swartley suggests subjects, the newspap selects one, an appointment is made at physician's convenience, the reporter spends 30 minutes with the doctor, and then the docto allowed to proofread the article before it is pu lished.

So far, the articles have dealt primarily w scientific subjects, explained in lay terms. "N we're going into the economics and issues medicine," says Mr. Swartley. "We're going to the people know when the physicians take stand."

County scenes

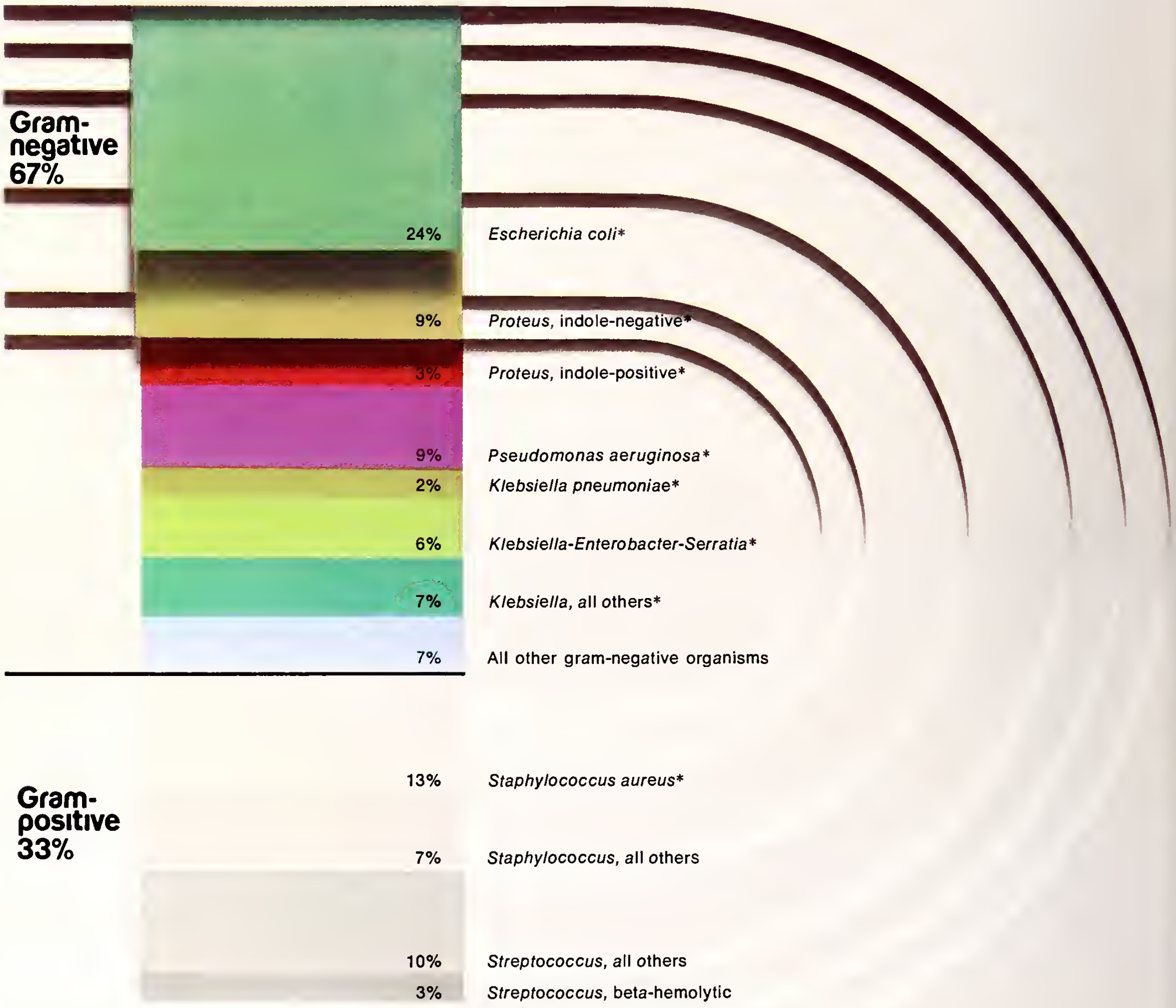
Schering

On all in-patient services... a major problem


2 out of 3
nosocomial infections
are gram-negative

Gram-negative bacteria magnified 10,000 times—color-tinted

Commonly encountered pathogens on all hospital services



	% Incidence	Pathogen
Gram-negative 67%	24%	*Escherichia coli**
	9%	*Proteus*, indole-negative*
	3%	*Proteus*, indole-positive*
	9%	*Pseudomonas aeruginosa**
	2%	*Klebsiella pneumoniae**
	6%	*Klebsiella-Enterobacter-Serratia**
	7%	*Klebsiella*, all others*
	7%	All other gram-negative organisms
Gram-positive 33%	13%	*Staphylococcus aureus**
	7%	*Staphylococcus*, all others
	10%	*Streptococcus*, all others
	3%	*Streptococcus*, beta-hemolytic
	0%	All other gram-positive organisms

Total pathogens 21,972
Source: Gosselin Audit of Pathology Cultures—1971

*GARAMYCIN Injectable is effective against
susceptible strains of the pathogens indicated

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Schering

A highly appropriate spectrum for today's problem pathogens

GARAMYCIN Injectable offers a high robability of effectiveness against susceptible trains of seven out of seven major gram-egative pathogens. These are:

Escherichia coli
Proteus, indole-negative
Proteus, indole-positive
Pseudomonas aeruginosa
Klebsiella }
Enterobacter } species
Serratia }

GARAMYCIN Injectable has also been shown o be effective in serious staphylococcal infecions. It may be considered in those infections vhen penicillins or other less potentially toxic lrugs are contraindicated and bacterial usceptibility testing and clinical judgment ndicate its use.

serious gram-negative infections neumonia, urinary tract infections, epticemia, and wound infections)*
e to susceptible organisms

Start with Garamycin

■ **Broad gram-negative spectrum**
Because of its broad gram-negative spectrum and its well-established clinical efficacy, GARAMYCIN Injectable can be considered for initial therapy in suspected as well as documented gram-negative sepsis.

Stay with Garamycin

■ **Susceptibility of causative organisms confirmed**
The results of susceptibility tests will, in most cases, demonstrate the causative organisms' sensitivity to GARAMYCIN Injectable. However, the decision to continue therapy with this drug should also be based on the severity of the infection and the important additional concepts contained in the Warning Box.

■ **Relatively low incidence of adverse reactions**
Risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.

■ **Bacterial resistance has not been a problem**
In the laboratory, resistance has been demonstrated to develop slowly in stepwise fashion. No one-step mutations to high resistance have been reported to date.

On all in-patient services...

Garamycin®
gentamicin sulfate
injectable
I.M./I.V.

40 mg. per cc.
Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin

WARNING
Patients treated with GARAMYCIN Injectable should be under close clinical observation because of the potential toxicity associated with the use of this drug.

Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment.

Monitoring of renal and eighth nerve function is recommended during therapy of patients with known impairment of renal function. This testing is also recommended in patients with normal renal function at onset of therapy who develop evidence of nitrogen retention (increasing BUN, NPN, creatinine or oliguria). Evidence of ototoxicity requires dosage adjustments or discontinuance of the drug.

In event of overdose or toxic reactions, peritoneal dialysis or hemodialysis will aid in removal of gentamicin from the blood.

Serum concentrations should be monitored when feasible and prolonged concentrations above 12 mcg./ml. should be avoided.

Concurrent use of other neurotoxic and/or nephrotoxic drugs, particularly streptomycin, neomycin, kanamycin, cephaloridine, viomycin, polymyxin B, and polymyxin E (colistin), should be avoided.

The concurrent use of gentamicin with potent diuretics should be avoided, since certain diuretics by themselves may cause ototoxicity. In addition, when administered intravenously, diuretics may cause a rise in gentamicin serum level and potentiate neurotoxicity.
USAGE IN PREGNANCY Safety for use in pregnancy has not been established.

See Clinical Considerations section which follows...

Schering

On all in-patient services...
in hospital-acquired gram-negative infections*

Garamycin®
gentamicin sulfate injectable

I.M./I.V.

40 mg. per cc.
Each cc. contains gentamicin sulfate equivalent to 40 mg gentamicin

Also available
GARAMYCIN® Pediatric Injectable, 10 mg. per cc.

GARAMYCIN® Injectable, brand of gentamicin sulfate U.S.P., injection, 40 mg./cc.
Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin
For Parenteral Administration

WARNING
Patients treated with GARAMYCIN Injectable should be under close clinical observation because of the potential toxicity associated with the use of this drug.

Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

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The concurrent use of gentamicin with potent diuretics should be avoided, since certain diuretics by themselves may cause ototoxicity. In addition, when administered intravenously, diuretics may cause a rise in gentamicin serum level and potentiate neurotoxicity.

USAGE IN PREGNANCY Safety for use in pregnancy has not been established.

INDICATIONS GARAMYCIN Injectable is indicated, with due regard for relative toxicity of antibiotics, in the treatment of serious infections caused by susceptible strains of the following microorganisms:

Pseudomonas aeruginosa, Proteus species (indole-positive and indole-negative), **Escherichia coli** and **Klebsiella-Enterobacter-Serratia** species.

Clinical studies have shown GARAMYCIN Injectable to be effective in septicemia and serious infections of the central nervous system (meningitis), urinary tract, respiratory tract, gastrointestinal tract, skin and soft tissue (including burns).

Bacteriologic tests to determine the causative organisms and their susceptibility to gentamicin should be performed.

Bacterial resistance to gentamicin develops slowly in stepwise fashion; there have been no one-step mutations to high resistance.

In suspected or documented gram-negative sepsis, GARAMYCIN may be considered as initial therapy. The decision to continue therapy with this drug should be based on the results of susceptibility tests, the severity of the infection, and the important additional concepts contained in the Warning Box. In the neonate with suspected sepsis or staphylococcal pneumonia, a penicillin type drug is usually indicated as concomitant antimicrobial therapy.

GARAMYCIN Injectable has been shown to be effective in serious staphylococcal infections. It may be considered in those infections when penicillins or other less potentially toxic drugs are contraindicated and bacterial susceptibility testing and clinical judgment indicate its use.

CONTRAINDICATIONS A history of hypersensitivity to gentamicin is a contraindication to its use.

WARNINGS See Warning Box.

PRECAUTIONS Neuromuscular blockade and respiratory paralysis have been reported in the cat receiving high doses (40 mg./kg.) of gentamicin. The possibility of these phenomena occurring in man should be considered if gentamicin is administered to patients receiving neuromuscular blocking agents such as succinylcholine and tubocurarine.

Treatment with gentamicin may result in overgrowth of nonsusceptible organisms. If this occurs, appropriate therapy is indicated.

ADVERSE REACTIONS

Nephrotoxicity: Adverse renal effects, as demonstrated by rising BUN, NPN, serum creatinine and oliguria, have been reported. They occur more frequently in patients with a history of renal impairment treated with larger than recommended dosage.

Neurotoxicity: Adverse effects on both vestibular and auditory branches of the eighth nerve have been reported in patients on high dosage and/or prolonged therapy. Symptoms include dizziness, vertigo, tinnitus, roaring in the ears and hearing loss. Numbness, skin tingling, muscle twitching, and convulsions have also been reported.

Note: The risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.

Other reported adverse reactions, possibly related to gentamicin, include increased serum transaminase (SGOT, SGPT), increased serum bilirubin, transient hepatomegaly, decreased serum calcium; splenomegaly, anemia, increased and decreased reticulocyte counts, granulocytopenia, thrombocytopenia, purpura; fever, rash, itching, urticaria, generalized burning, joint pain, laryngeal edema; nausea, vomiting, headache, increased salivation, lethargy and decreased appetite, weight loss, pulmonary fibrosis, hypotension and hypertension.

DOSAGE AND ADMINISTRATION GARAMYCIN Injectable may be given intramuscularly or intravenously.

For Intramuscular Administration:

PATIENTS WITH NORMAL RENAL FUNCTION*

Adults: The recommended dosage for GARAMYCIN Injectable for patients with serious infections and normal renal function is 3 mg./kg./day, administered in three equal doses every 8 hours.

For patients weighing over 60 kg. (132 lb.), the usual dosage is 80 mg. (2 cc.) three times daily. For patients weighing 60 kg. (132 lb.) or less, the usual dose is 60 mg. (1.5 cc.) three times daily.

In patients with life-threatening infections, dosages up to 5 mg./kg./day may be administered in three or four equal doses. This dosage should be reduced to 3 mg./kg./day as soon as clinically indicated.

*In children and infants, the newborn, and patients with impaired renal function, dosage must be adjusted in accordance with instructions set forth in the Package Insert.

For Intravenous Administration:

The intravenous administration of GARAMYCIN Injectable is recommended in those circumstances when the intramuscular route is not feasible (e.g., patients in shock, with hematologic disorders, with severe burns, or with reduced muscle mass).

For intravenous administration, in adults, a single dose of GARAMYCIN Injectable may be diluted in 100 or 200 cc. of sterile normal saline or in a sterile solution of dextrose 5% in water; in infants and children, the volume of diluent should be less. The concentration of gentamicin in solution, in both instances should normally not exceed 1 mg./cc. (0.1%). The solution is infused over a period of 1 to 2 hours.

The recommended dose for intravenous administration is identical to that recommended for intramuscular use.

GARAMYCIN Injectable should not be physically pre-mixed with other drugs, but should be administered separately in accordance with the recommended route of administration and dosage schedule.

HOW SUPPLIED GARAMYCIN Injectable, 40 mg. per cc., 2 cc. multiple-dose vials for parenteral administration.

Also available, GARAMYCIN Pediatric Injectable, 10 mg. per cc., 2 cc. multiple-dose vials for parenteral administration. APRIL, 1972
AHFS Category 8:12.28

For more complete prescribing details, consult Package Insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.

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*Due to susceptible organisms

SLR-301

Doctor Barnes questions 'the crisis'

Muskegon County Medical Society President James W. Barnes, MD, reflected on the state of medical practice today in a recent issue of the *MCMS Bulletin.*

Wrote Doctor Barnes, "We think we are practicing better than ever, but according to the media and to much of Congress, there is a crisis in medical care. We think we have reached an expertise in surgery that permits successful operations on many that would have been denied them previously, only to read that too many operations are being done. We think that we are placing special emphasis on patient education and informed consent, only to have patients assail us for assault, malpractice and unethical behavior. It seems the harder we try, the worse things get.

"Before striking back in anger, however, let us remember that the medical crisis is the product of the media and the politicians. Remember that the media and politicians are way down the list of people trusted by the public. Remember that your patient may not be too sure about some doctors but he trusts you more than anyone else on this earth."

Detroit Medical Society has video tape on VD

The Detroit Medical Society wishes to inform Michigan physicians that it has produced an hour-long television program on venereal disease now available on video tapes to schools, churches and other community organizations.

The program features a question and answer period between 12 high school students and four medical specialists, who are Charles Inniss, MD, pediatrician and moderator; Barbara Jenkins, MD, pathologist; Ethelene Crockett Jones, MD, obstetrician-gynecologist and Richard Smith, MD, dermatologist.

Further information may be obtained from William Mays, MD, president, Detroit Medical Society, 13800 Livernois, Detroit.

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Medical education psychiatrists' topic at annual meeting

Three mornings of discussion of current problems in medical education, especially as they relate to psychiatric residency programs, are planned by the Michigan Psychiatric Society at its annual meeting July 13-15 at the Grand Hotel, Mackinac Island.

Speakers will include national leaders in the field of psychiatric education.

A highlight will be a debate between proponents of the "traditional" and "modern" schools of psychiatric training, who are, respectively, Garfield Tourney, MD, professor and chairman, Department of Psychiatry, Wayne State University School of Medicine, and Donald Weston, MD, professor of psychiatry and associate dean for clinical and community affairs, Michigan State University College of Human Medicine.

Other speakers will include Robert L. Stubblefield, MD, Boulder, Colo., vice president of the American Board of Psychiatry and Neurology; Harvey Strassman, MD, Chicago, president, American Association of Directors of Psychiatric Residency Training, and Norbert B. Enzer, MD, chairman, Department of Psychiatry, MSU College of Human Medicine.

The meetings are open to any interested physicians and allied health personnel, according to Kenneth Pitts, MD, West Bloomfield, president, Michigan Psychiatric Society.

Convention information may be obtained from Chairman Norman Rosenzweig, MD, chairman, Department of Psychiatry, Sinai Hospital of Detroit, 6767 W. Outer Drive, Detroit, 48235, while inquiries regarding golf should be sent to C. W. Fountain, MD, 2012 Monroe, Dearborn, 48124.

Kent Foundation awards 47 loans

The annual report of the Kent Medical Foundation reveals that during 1972-73 a total of 47 loans were made to medical students. The 47 included 22 students at the University of Michigan, 13 at Wayne, and three at Michigan State. The total amount of loans represented $72,092.

Harold E. Bowman, MD, Grand Rapids, was reelected president of the foundation at its 12th annual meeting. Anna H. Broecker, MD, is secretary-treasurer.

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350 MDs expected for July 26 - 27 C - P - T conference

Planners of the 53rd Annual Coller-Penberthy-Thirlby Medical Conference July 26-27 in Traverse City expect 350 Michigan physicians to attend their program at the Park Place Motor Hotel.

A distinguished faculty including out-of-state physicians will present the sessions. John A. Gronvall, MD, dean, U-M Medical School, and director, U-M Medical Center, will serve as toastmaster at the Thursday evening dinner.

Out-of-state faculty members will include J. Garrott Allen, MD, professor of surgery, Stanford University School of Medicine; Evan Calkins, MD, chairman, Department of Medicine, State University of New York at Buffalo School of Medicine; William A. Altemeier, MD, chairman, Department of Surgery, University of Cincinnati College of Medicine; Lester R. Dragstedt, PhD, MD, research professor of surgery and professor of physiology, University of Florida College of Medicine; George E. Block, MD, head, section of Head and Neck Surgery, University of Chicago School of Medicine; Marion S. DeWeese, MD, chairman, Department of Surgery, the University of Missouri Medical Center; Paul H. Jordan, MD, professor of surgery, Department of Surgery, Baylor College of Medicine; Mark A. Hayes, MD, professor of surgery, Yale University School of Medicine; Allan C. Barnes, MD, vice president in charge of biomedical affairs, the Rockefeller Foundation; George D. Zuidema, MD, director, Department of Surgery, Johns Hopkins University School of Medicine, and Merle M. Musselman, MD, professor of surgery, The University of Nebraska College of Medicine.

Chairman of the program is Laurence P. Skendzel, MD, Munson Medical Center, Traverse City.

Vietnam program needs physician volunteers

Michigan physicians are encouraged to be among the 100 volunteers required in 1973 to serve with the AMA's Volunteer Physicians for Viet Nam program. To date, 750 individual physicians, including 22 from Michigan, have served 950 tours of duty with the program, which helps to meet the health and medical needs of the military and civilians in physician-poor Vietnam.

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Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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(Continued on page 449)

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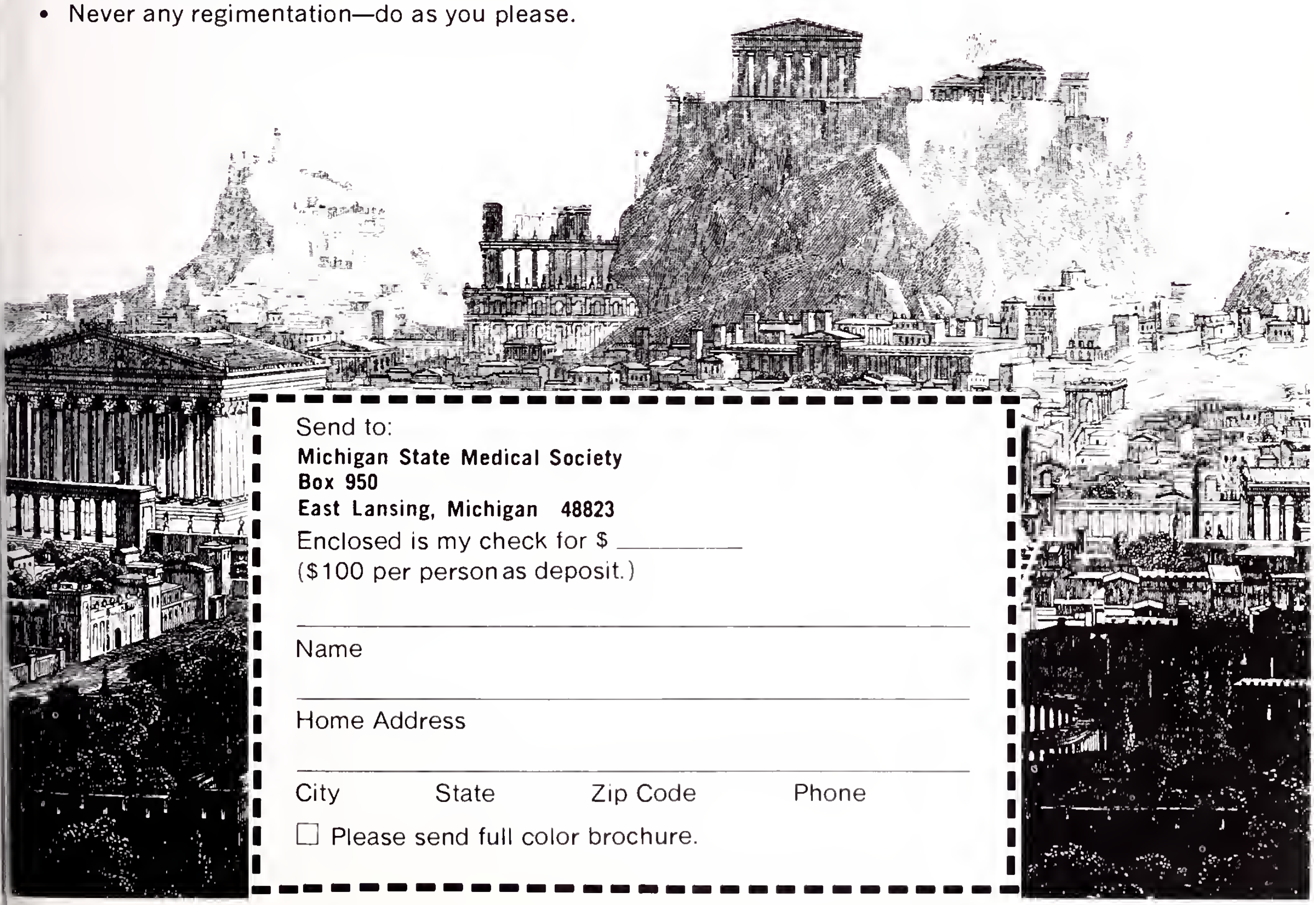

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OPHTHALMOLOGIST—A very excellent opportunity for well-trained man, downtown Detroit, one-man office, worth investigating. Michael A. Wainstock, MD, 621 David Whitney Bldg., Detroit, MI 48226 (313) 961-7107 Office, (313) 864-2323 Home.

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UNIVERSITY HEALTH PHYSICIAN—Athletic Medicine Coordinator: Staff position available for M.D. in Detroit. Position includes responsibility to Athletic programs of the University plus general clinic duties. Competitive salary and fringe benefits including retirement and disability programs offered. Experience in managing athletic injuries desirable. For information send vitae to Andrew J. Smith, Jr., M.D., Director, Health Services, Wayne State University, Detroit, Michigan 48202. The University is an Affirmative Action/Equal Opportunity Employer.

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Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone These changes appear to be related to dosage of the drug Theretore, in the presence of any changes in liver function tests, drug should be discontinued.

PRECAUTIONS: Prolonged dosage of androgen may result in sodium and fluid retention This may present a problem, especially in patients with compromised cardiac reserve or renal disease In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient s cardiovascular capacity.

CONTRAINDICATIONS· Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast Contraindicated in the presence of severe liver damage.

WARNINGS: If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development Hypersensitivity and gynecomastia may occur rarely PBI may be decreased in patients taking androgens Hypercalcemia may occur, particularly during therapy for metastic breast carcinoma If this occurs, the drug should be discontinued

ADVERSE REACTIONS: Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastic breast carcinoma This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia

DOSAGE AND ADMINISTRATION. Dosage must be stricly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as an average daily dosage guide.

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In the male:	
Eunuchoidism and eunuchism	10 to 40 mg.
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Postpuberal cryptorchism	30 mg.

HOW SUPPLIED: 5, 10, 25 mg. in bottles of 60, 250.

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MAFP Scientific Assembly July 16 - 18

The 27th annual Scientific Assembly of the Michigan Academy of Family Physicians is planned July 16-18 at the Park Place Motor Inn, Traverse City, following the MAFP Congress of Delegates.

Topics will include prostaglandins, enzymology, treatment of shock, treatment of fractures, the multiply injured patient, pediatric orthopedic problems, neonatology and pediatric immunology, urology and neurology.

Speakers will include distinguished visiting specialists and members of the MAFP. The assembly is supported by educational grants from a number of pharmaceutical companies.

WELCOME/Continued

Robert J. VandenBerg, MD, 200 Taft St., Zeeland, 49464
Desmond P. Waters, MD, 111 E. Court St., Ludington, 49431
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In memoriam

Myra E. Babcock, MD
Pleasant Ridge

Long-time Detroit physician Myra E. Babcock, MD, died April 10 at the age of 90. She was a family physician.

Doctor Babcock had practiced in the Detroit area for 63 years and had been associated with the Grace Hospital. She was graduated from the Detroit College of Medicine and was founder and director from 1918 to 1949 of the school of anesthesia at the Grace Hospital.

She was a cofounder of the Anti-Cruelty Association of Detroit and was a member of the Blackwell Medical Society and the Medical Women's Association of the U. S.

Wyman D. Barrett, MD
Grosse Pointe Farms

Wyman D. Barrett, MD, former vice chief of staff and head of surgery at Harper Hospital, Detroit, died April 27 at the age of 84.

A native of Ontario, Doctor Barrett was graduated from the University of Toronto medical school. He was past president of the Wayne County Medical Society and a member of the American Academy of Medicine and the American Academy of Surgery. He was a MSMS delegate to the American Medical Association for 16 years and was a professor emeritus of the Wayne State University School of Medicine.

Donald E. Christensen, MD
Mt. Pleasant

The medical superintendent of the Mt. Pleasant State Home and Training School, Donald Earl Christensen, MD, died April 9 at the age of 49.

Doctor Christensen was former medical director of the Gaylord State Home and was a graduate of Western Reserve University school of Medicine. He was an associate on the Central Michigan University faculty.

John P. Hubbard, MD
Boca Raton, Fla.

John Philip Hubbard, MD, former chief of staff at St. Joseph Mercy Hospital, Detroit, died April 26 at the age of 76.

Doctor Hubbard was graduated from the University of Toronto Medical School and had practiced medicine for 47 years in Detroit. He was a generalist but had retired to Florida in 1968. He had served with the Canadian Army.

Paul B. Kilmer, MD
Reed City

Long-time Reed City physician and civic leader, Paul Bernard Kilmer, MD, died April 20 at the age of 71.

Doctor Kilmer, a family physician, had served Reed City for over 40 years. He was graduated from Northwestern Medical School and was a member of the American Academy of Family Physicians and the Flying Physicians Association. He had been a Federal Aviation Examiner since 1939 and served on the Osceola County Draft Board for 25 years.

Doctor Kilmer was a member of the Reed City Board of Education for 23 years, 15 of them as president. In 1969 he was honored by civic groups with an open house and testimonial observance.

Raymond H. Koebel, MD
Pompano Beach, Fla.

Retired Detroit-area physician Raymond H. Koebel, MD, died April 21 at the age of 74.

A generalist and surgeon, Doctor Koebel had retired in 1972. He was a graduate of Wayne State University School of Medicine and was affiliated with Deaconess Hospital. He was a member of the American College of Surgeons.

Thomas A. McInerney, MD
Escanaba

Thomas Anthony McInerney, MD, Escanaba, died March 28 at the age of 65. Doctor McInerney was a native of Chicago and had resided in Escanaba since 1940.

He was a graduate of the University of Illinois Medical School and was affiliated with St. Francis Hospital of Escanaba. He was a family physician who devoted most of his practice to obstetrics and gynecology.

Doctor McInerney was a past president of the Delta-Schoolcraft Medical Society and was a member of the Society of Military Surgeons.

Cecil E. Tate, MD
Jackson

Cecil Earl Tate, MD, Jackson generalist and surgeon, was found shot to death April 25 in a parking lot behind his office. He was 67 years old.

Doctor Tate was a graduate of the University o Illinois medical school and was affiliated with W A. Foote and Mercy hospitals of Jackson. He was member of the American Society of Abdomina Surgeons, the Flying Physicians Association, th American College of Gastroenterology and th American Association of Family Physicians.

MSMS House adopts resolution:

Begin new efforts to inform public, MDs about "dangers of chiropractic"

The spring meeting of the MSMS House of Delegates, May 13-15, 1973 adopted the following resolution dealing with chiropractic:

"RESOLVED: That the MSMS vigorously pursue an active role in educating the consumer public and the medical profession regarding the fallacies, pitfalls and dangers of chiropractic; and be it further

"RESOLVED: That MSMS oppose third party payments to chiropractors; and be it further

"RESOLVED: That MSMS give strong, active support to the passage of anti-advertising legislation aimed at curbing the deceptive, fraudulent, harmful advertising by chiropractors; and be it further

"RESOLVED: That the MSMS support any action that might be necessary to require as a pre-requisite for future chiropractic licensure in the State of Michigan, a degree from a school that is accredited by an accrediting agency recognized by either the U.S. Office of Education or the National Commission on Accrediting; and be it further

"RESOLVED: That MSMS seek ways and means to protect the public from the misuse of x-ray equipment by chiropractors; and be it further

"RESOLVED: That MSMS inform its membership that it is considered unethical by the AMA and, henceforth, by the MSMS for a doctor of medicine to refer a patient to a chiropractor for any reason.

The adopted resolution now has been assigned by MSMS Council Chairman Robert M. Leitch, MD, to the Chiropractic Study Task Force chaired by Richard Gascoigne, MD, Adrian. The task force, aided by consultants named by many component medical societies, is one of several operating under the general framework of the MSMS Committee on Public Relations.

The MSMS Committee on Legal Affairs, and others will help implement portions of the resolution as requested by the special task force.

"At Your Own Risk" author urges legislative review; recommends two steps

A recent book by Ralph Lee Smith, an independent researcher, now tells the public about chiropractic. Published by Simon and Schuster, the book, "At Your Own Risk," is available at many newspaper and magazine stands and is available at libraries.

Mr. Smith, after a personal, penetrating investigation of chiropractic, tells why he feels chiropractic should be subject to immediate legislative review.

Mr. Smith reaches this conclusion about chiropractic: "The theory of chiropractic is scientifically false and treatments given in accordance with the theory bear no relationship to the cause or cure of human disease. Its practice should therefore be prohibited, and its personnel should be retrained to enter other professions."

Mr. Smith proposed two steps to be taken by the state legislature: "The first step, and one that must be taken immediately, is to prohibit further use of X-ray by chiropractors . . . "The next step is for each state to create an orderly program for withdrawing chiropractic licenses."

Information about how to obtain copies may be secured from the MSMS Department of Communications or Mail Service Department, Pocket Books, 1 West 39th Street, NYC 10018.

Two chiropractic associations differ over philosophy

There are two chiropractic national organizations, each with a different philosophy.

The International Chiropractors Association (ICA) represents the more restrictive approach usually limiting diagnostic effort to the determination of structural disrelationships of the spinal column and restricting the treatment method to spinal adjustment. The ICA has approximately 4,000 members, frequently referred to as "straights." This association is closely identified with the Palmer College in Davenport, Iowa.

The American Chiropractic Association (ACA) has about 7,500 members, frequently referred to as "mixers." The ACA has departed somewhat from the strict Palmer philosophy in including dietary and nutritional supplementation and physiotherapy as treatment methods in addition to the traditional spinal adjustment.

MSMS asks state attorney general, Consumer Council, MPA to review "misleading" chiropractic advertising

By Richard Gascoigne, MD, Chairman
MSMS Task Force on Chiropractic

MSMS has received in recent months more and more complaints about chiropractic advertising.

The Chiropractic Study Task Force is systematically collecting the newspaper advertisements for review. Copies of the ads are being directed for study to the MSMS legal counsel.

Copies are being sent to the Michigan Press Association for review.

Copies are being directed also to the office of the Attorney General of Michigan.

* * *

THE BEST WAY TO illustrate how misleading these chiropractic ads can be is to quote from some of them:

In southern Michigan, a chiropractor ran an ad in the daily paper, with the message:

> "It is important to have your children examined by a doctor of chiropractic as soon after birth as possible. Quite often when a baby is born, the medical doctor may twist or turn the baby's neck during delivery. This can, and often does cause misalignments of the spine and especially the neck. If these misalignments are not corrected by a chiropractor, they can lead to health problems later."

An ad in one of the biggest Michigan daily papers reports that "a partial list of conditions most frequently treated through chiropractic care include . . . chest pains, ulcers, high blood pressure, skin diseases, thyroid conditions, functional heart conditions, menstrual irregularities, hemorrhoids, . . . "

A chiropractor in northern Michigan said in his ad that "Prompt chiropractic care will bring quick and lasting results" to polio patients. He alleged that adjustment of spinal distortion "is the distinctive chiropractic corrective procedure for polio."

* * *

THE READERS OF A BIG CENTRAL Michigan daily found an ad that claimed great success with such conditions as emotional disorders, migraine headaches, indigestion, allergies, etc. The ad declared, "the vast majority of these cases had also been previously diagnosed and treated by practitioners other than chiropractors."

A chiropractor in the southeastern corner of Michigan ran an ad to contend that "the chiropractor, with his scientific knowledge of the spinal column and the operation of spinal nerves, is excellently equipped and trained to combat stroke."

The readers of one daily paper found a chiropractic ad pointing out that there are over 1,800 neurological conditions which can be corrected by chiropractic.

Many ads appeal to parents. A chiropractor up north advertised, "Don't overlook the opportunity of giving your child competent chiropractic care in measles, as its complications are many." The ad repeated the message many times, "chiropractic plays an important role in the treating of measles."

Another ad in a weekly paper appealed to the readers, "Can't get along with your in-laws? Send them in for adjustments."

Quotes from HEW, AFL-CIO, Wisconsin Study, Others . . .

Groups outside of medicine challenge chiropractic education and practice

Physicians must become more effective in helping the public understand what is being said about chiropractic by many groups *outside of medicine.*

Physicians and all those in the scientific community have long felt that chiropractors lack the necessary education and training to diagnose and treat human diseases and illness.

These same conclusions have been reached also by leaders in government, labor, the consumer movement, and so on.

Objective opinions reached after independent study are available for all to evaluate.

These four pages do not begin to be sufficient to print the outside opinions, but let's include some of the testimony presented by leaders outside of medicine.

* * *

IN 1966 PRESIDENT JOHNSON appointed the National Advisory Commission on Health Manpower with the mandate "to develop appropriate recommendations for action by government or by private institutions, organizations or individuals for improving the availability and utilization of health manpower."

Tucked away in a little-known section of the Commission's 1967 report is this statement: "Although chiropractic is not the only existing cult, it is the only one which still constitutes a significant hazard to the public." In discussing the state licensure of chiropractors, the National Advisory Commission on Health Manpower also says: "Ideally . . . the statutes should be repealed to remove the cult's shield of legitimacy."

In 1967, the U. S. Congress ordered the Secretary of Health, Education, and Welfare to make a study of chiropractic, to determine whether chiropractic services should be provided under the Medicare legislation.

The findings resulting from this independent study of chiropractic were submitted to Congress in December 1968 by former HEW Secretary Wilbur J. Cohen.

* * *

THIS 50-PAGE COHEN REPORT is the most definitive, totally documented analysis of chiropractic ever made. It was produced after chiropractic's foremost spokesmen, educators, and practitioners were given opportunity to present their best evidence. The report states HEW's findings forcefully and simply: Chiropractic theory and practice are not based upon the body of basic knowledge related to health, disease, and health care that has been widely accepted by the scientific community. Moreover, irrespective of its theory, the scope and quality of chiropractic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment.

* * *

THE AFL-CIO, the nation's largest labor organization and perhaps the nation's most influential consumer group, submitted to Congress in September 1970 what the AFL-CIO calls its "Fact Sheet on Chiropractic." This is a ringing denunciation of chiropractic as a health-care provider, pointing up the invalidity of the chiropractic theory, its educational shortcomings, and its other inadequacies.

The AFL-CIO concludes its Fact Sheet with this unequivocal recommendation to Congress: "Care of patients should only be entrusted to those who have a sound scientific knowledge of disease and whose experience and competence render them capable of diagnosing and treating patients by utilizing all the resources of modern medicine. Since neither chiropractic theory nor the quality of chiropractic education equip chiropractors to do this, the AFL-CIO opposes coverage of chiropractic services in the Medicare program."

* * *

The AFL-CIO Executive Council on February 26, 1973, issued a statement on "Coverage of Chiropractic Services in Governmental Programs." The statement, in part, said,

"A major objection of coverage of chiropractic services in public programs is the claim that chiropractors may attempt to substitute their services for those of a physician. He (the chiropractor) may seek to treat illnesses outside his field of competence."

"We do not believe that chiropractors should perform functions of a physician or serve as a point of entry into the health system."

* * *

"Chiropractic treatment, designed to eliminate causes that do not exist while denying the existence of the real causes, is at best worthless — and at worst, mortally dangerous."

That is a quotation from a January 1969 issue of the National Council of Senior Citizens official

Study committee urges qualified experts review chiropractic use of X-ray

The questionable use of X-ray by chiropractors recently drew special attention by the Wisconsin chiropractic study committee. (See other articles about the Wisconsin report.)

The Wisconsin committee sent a questionnaire to chiropractors and to physicians about the use of X-rays. Over 91 per cent of the chiropractors who responded reported that they use X-ray equipment. The committee found that only 39 per cent of the responding doctors of medicine (excluding radiologists who specialize in X-ray) used X-ray.

The committee further stated: "The educational evaluation raises some doubt concerning the adequacy of chiropractic training in the use of X-ray equipment." The committee report also stated, "Many of the chiropractic X-rays were reported to be of large size (14 inches x 36 inches) and the possibility of excessive exposure to radiation is evident."

The Wisconsin report "recommends that this matter (use of X-ray) be further studied by qualified experts, and that such regulations as are appropriate be enacted and enforced."

Continued: many groups challenge chiropractic

newspaper, "Senior Citizen News." The two-page article was entitled "Why Chiropractic Cult Cannot Provide Quality Health Care!"

NCSC has almost 3 million members 65 years of age and older.

The American Public Health Association, composed of administrators of the nation's public health programs, at its annual meeting in November 1969, recommended "that States reevaluate their existing licensure programs for chiropractors and naturopaths to determine whether such licenses should be further restricted or abolished, and that existing restrictions be more rigorously policed." And it urged, "that professional and consumer groups undertake appropriate consumer education on the hazards of unscientific health care, including chiropractic and naturopathy."

NATIONAL ASSOCIATION OF LETTER CARRIERS incorporated chiropractic into its health insurance plan when it was adopted in 1960, and on January 1, 1966 eliminated chiropractors from its health plan. The report published by the Letter Carriers, based on their more than five years of dealing with chiropractic, said in part: "By mid-1965, we were convinced that it would be a greater disservice to our members to continue recognition of chiropractors than to eliminate them from our contract. If recognition continued, and the abuses also continued, the inevitable result would be financial disaster for many of our members."

In August 1970, the Consumer Federation of America, representing 184 local, state and national consumer-oriented organizations with millions of members throughout the country, adopted a strongly worded resolution that chiropractic constitutes a health hazard.

Other groups also have spoken out in opposition to chiropractic. They include the AMA, American Cancer Society, the American College of Radiology, the American Academy of Orthopaedic Surgeons, the Health Insurance Association of America, and the National Association for Retarded Children, among others.

Wisconsin Study Group Visits Palmer College

What is a chiropractic college like?

The Palmer College in Davenport, Iowa, was visited by the entire Wisconsin task force on chiropractic and the final Wisconsin report contains a section about their observations. Briefly here are some of the conclusions:

1. "The faculty-student ratio is too low for effective teaching." There are 32 faculty members for 1,300 students. Seven of the 32 carry administrative responsibilities too and many maintain active private practices.

2. "Teaching of the basic sciences is done by persons who themselves lack adequate training." The highest non-chiropractic academic degrees were one M. S. and one M. A., both held by persons who also function as administrators.

3. "Library facilities are inadequate. The collection of books is small and obviously not up to date." There were no journals of the basic sciences in evidence.

4. The quality of instruction was criticized. The emphasis was found to be on rote learning.

5. "There were no research projects underway at Palmer College."

6. "Requirements for admission are generally regarded as sub-standard for academic achievement."

7. During the Wisconsin committee's tour "no laboratories were pointed out."

In summary, the report stated, "the deficiencies are too pervasive to permit an adequate educational experience."

President's page

John J. Coury, MD
MSMS President

Michigan, Wisconsin studies support MSMS move to tell public about chiropractic

By John J. Coury, MD
President, MSMS

The recent decision of the MSMS House of Delegates to "vigorously pursue an active role in educating the consumer public about the fallacies, pitfalls and dangers of chiropractic" is indeed a wise, timely position. The needs for such an educational thrust, I feel, are great today.

This new MSMS directive is in the area identified also by the Michigan Citizens Committee to the State Department of Education. And it's the same concern voiced more recently by the chiropractic study committee of the Governor's Health Planning and Policy Task Force in neighboring Wisconsin.

Let me quote for you from each of the reports to add the impact of independent, citizen groups . . .

* * *

THE APPEAL FOR CONSUMER EDUCATION about chiropractic was made in 1970 in Michigan by the Michigan Citizens Committee to the Michigan Department of Education. The committee, comprised of many lay and professional leaders, concluded, "In light of the extensive body of data that has been accumulated from the numerous studies of the subject, it is clear that the extension and/or expansion of the practice of chiropractic in the state of Michigan would not be in the best interest of the health and welfare of the citizens of the state.

"Solution of the problems inherent in the existence of unscientific schools of practice, such as chiropractic, requires a two-pronged approach.

"First, there need to be expanded and improved efforts to educate consumers of health services about the effective use of the scientifically based health care system available to them throughout the state.

Secondly, efforts to expand the scope or area of practice of chiropractic in the state of Michigan should be opposed. One such effort was avoided only by a Governor's veto in 1967. Moreover, consideration should be given to a moratorium on the issuance of any new licenses to chiropractors."

These are direct quotes from Report of the Citizens Committee on Educational and Health Care, Education for Health Care in Michigan Series 1, No. 5, Michigan Department of Education, Lansing, Michigan, 1970.

* * *

A PROPOSAL TO "educate all citizens regarding the nature of chiropractic theory, its lack of scientific validity and the potential hazards associated with its use" was made by the chiropractic study committee to the Wisconsin Governor's Health Planning and Policy Task Force.

That is the first recommendation of that report, completed in 1972. The chiropractic study committee was chaired by Gilda B. Shellow, a Milwaukee attorney, and included Robert B.

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Durkin, vice president of the Milwaukee County Labor Council AFL-CIO, and a member of the Board of Directors of the Wisconsin State Labor Council AFL-CIO.

The report recognized that "every individual has the right to control his own body and the privacy thereof" but that "the state must assume the responsibility for providing the citizen with the information necessary to engage in the decision-making process." The study committee proposed that informational programs about chiropractic be carried out by the Education Committee of the Wisconsin Health Policy and Program Council.

The committee reached its conclusions after eight public hearings, a visit to the Palmer College of Chiropractic, a study of the replies from 256 chiropractors to a task force questionnaire, and meetings with the leaders of the Wisconsin Chiropractic Board of Examiners and the Wisconsin Chiropractic Association, etc.

The extensive report, available from the state of Wisconsin for study, concluded that it is anachronistic to permit an academically unrecognized, scientifically unproved, and medically uncontrolled method of health care to impair optimum quality of care.

Au Revoir

By A. Stewart Kerr
MSMS Legal Counsel

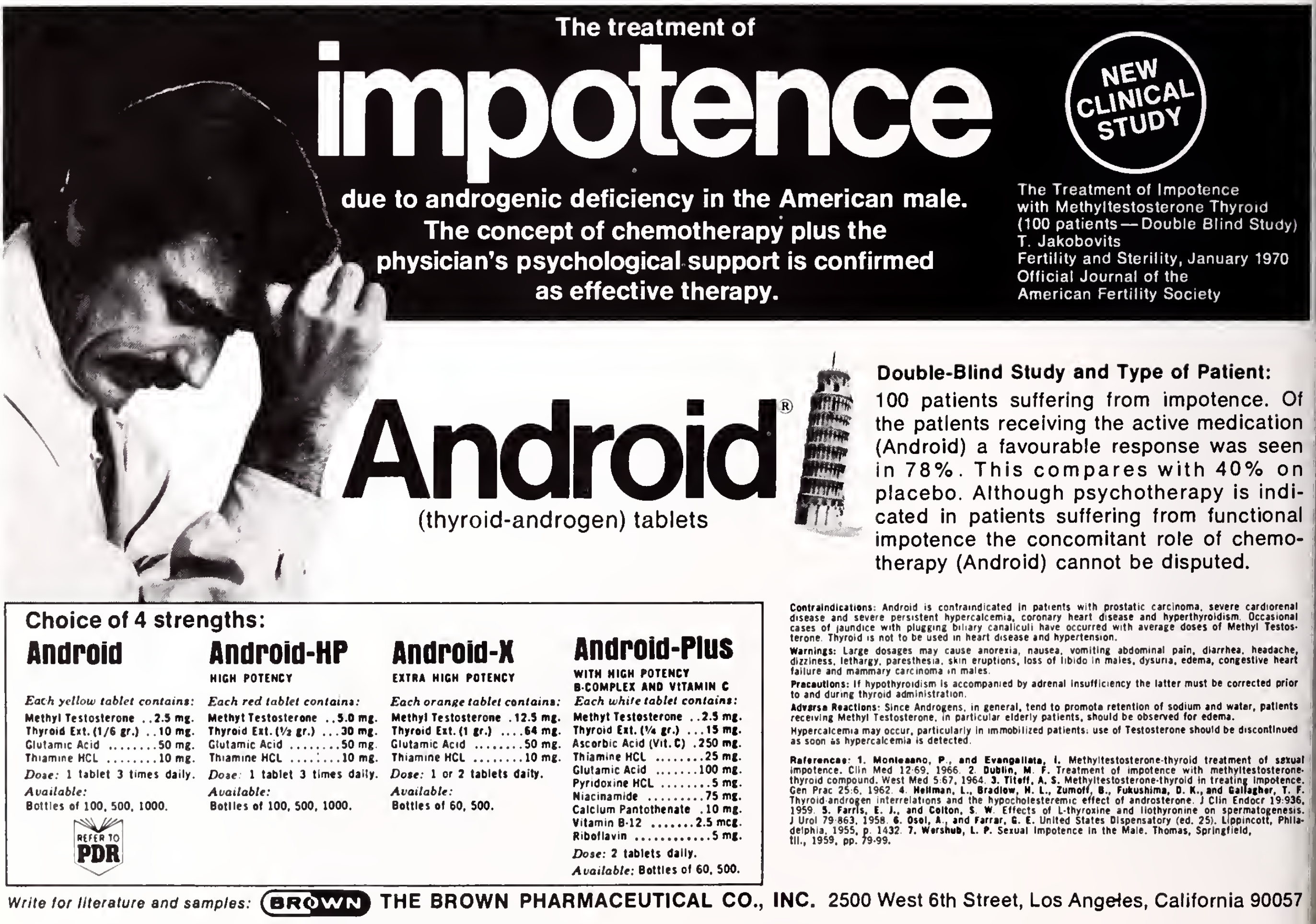
We have for several years preached 3 basics that avoid malpractice suits: practicing good medicine; good records; communication. At a recent medical meeting, a doctor challenged us to name some one specific thing—just one item—that would improve patient communication/good will.

One answer: Learn to say "good-bye."

Good-Bye? Yes. "Good-Bye" when you leave your office patient. The doctor mumbles a bit and departs with no clear indication concerning his return. Some even say "wait here," falsely suggesting the doctor's return or that some other instruction is involved (resting, awaiting a prescription, awaiting the setting of another date by a secretary, etc.). The patient sits in his cubicle, uncertain whether to wait or depart. He leaves with a bad taste in his mouth.

Doctor, a pleasant good-bye, even a handshake, costs you nothing. Litigation costs plenty.

"Good-bye."



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The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

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T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the American Fertility Society

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Double-Blind Study and Type of Patient: 100 patients suffering from impotence. Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% on placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

Choice of 4 strengths:

Android	**Android-HP** HIGH POTENCY	**Android-X** EXTRA HIGH POTENCY	**Android-Plus** WITH HIGH POTENCY B-COMPLEX AND VITAMIN C
Each yellow tablet contains: Methyl Testosterone ..2.5 mg. Thyroid Ext. (1/6 gr.) ..10 mg. Glutamic Acid ....50 mg. Thiamine HCL ....10 mg. *Dose:* 1 tablet 3 times daily. *Available:* Bottles of 100, 500, 1000. REFER TO PDR	*Each red tablet contains:* Methyl Testosterone ..5.0 mg. Thyroid Ext. (½ gr.) ...30 mg. Glutamic Acid ....50 mg. Thiamine HCL ....10 mg. *Dose:* 1 tablet 3 times daily. *Available:* Bottles of 100, 500, 1000.	*Each orange tablet contains:* Methyl Testosterone .12.5 mg. Thyroid Ext. (1 gr.) ....64 mg. Glutamic Acid ....50 mg. Thiamine HCL ....10 mg. *Dose:* 1 or 2 tablets daily. *Available:* Bottles of 60, 500.	*Each white tablet contains:* Methyl Testosterone ..2.5 mg. Thyroid Ext. (¼ gr.) ...15 mg. Ascorbic Acid (Vit. C) .250 mg. Thiamine HCL ....25 mg. Glutamic Acid ....100 mg. Pyridoxine HCL ....5 mg. Niacinamide ....75 mg. Calcium Pantothenate .10 mg. Vitamin B-12 ....2.5 mcg. Riboflavin ....5 mg. *Dose:* 2 tablets daily. *Available:* Bottles of 60, 500.

Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiorenal disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.

Hypercalcemia may occur, particularly in immobilized patients; use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References: 1. **Monleaano, P., and Evangallata, I.** Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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[1] Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

Michigan mediscene

July 9-Aug. 11 — Summer Institute on Social Gerontology, graduate study programs on the U-M campus, contact: Institute of Gerontology, 543 Church St., Ann Arbor, 48104.

July 13-15 — Annual meeting, Michigan Psychiatric Society, Grand Hotel, Mackinac Island, contact: R. Norman Rosenzweig, MD, chairman, Department of Psychiatry, Sinai Hospital of Detroit, 6767 W. Outer Drive, Detroit, 48235

July 14-15 — Summer Seminar, Michigan Branch, American Association of Medical Assistants, Grand Hotel, Mackinac Island, contact: Mrs. Louise Cole, 215-A S. Main, Ann Arbor, 48008

July 14-18 — Annual meeting and scientific program, Michigan Academy of Family Physicians, Park Place Motor Hotel, Traverse City, contact: Rita M. Feldkamp, 933 Wing St., Plymouth, 48170

July 26-27 — 53rd annual Coller - Penberthy-Thirlby Medical Conference, Park Place Motor Inn, Traverse City, contact: Lawrence P. Skendzel, MD, Munson Medical Center, Traverse City, 49684

Aug. 3-4 — Midsummer meeting of The Council, Boyne Highlands, contact: Warren Tryloff, MSMS director

Sept. 19 — The Council, MSMS headquarters, contact: Warren Tryloff, director

Sept. 26 — Annual Muskegon County Trauma Symposium, Holiday Inn, Muskegon, contact: G. W. Anessa, MD, 1470 Peck St., Muskegon, 49441

Sept. 22-23—Annual September Leadership Training Seminar, Holiday Inn-Crosstown, Kalamazoo, contact Chairman Alice Covell, c/o Robert Ferguson, MD, 1141 S. Rose, Kalamazoo, 49008.

Oct. 4-5 — Annual Harold C. Mack Symposium on the Physiology and Pathology of Human Reproduction, "Regulation of Fertility," at headquarters of Engineering Society of Detroit, contact: Kamran S. Moghissi, MD, C.S. Mott Center, 275 E. Hancock, Detroit, 48201

Oct. 7-11 — 108th MSMS Annual Session, Sheraton-Cadillac Hotel, Detroit, contact: Richard Campau, MSMS headquarters, for House of Delegates information, and Helen Schulte, MSMS headquarters, for scientific meeting information.

Oct. 8-10—Annual meeting of the MSMS Auxiliary, Pontchartrain Hotel, contact: Mrs. Dwight J. Dutcher, convention chairman, 711 S. Oxford Road, Grosse Pointe, 48236

Jan. 15, 1974 — Midwinter board meeting, MSMS Auxiliary, at MSMS headquarters, contact: Mrs. William J. Jones, president-elect, 15839 Crescent Drive, Allen Park, 48101

The diabetic who has too much...

too much sugar, too much fat.

Maybe the last thing she needs is more of her own insulin. Especially when you consider that many overweight diabetics already have normal or high levels of endogenous insulin and that insulin is lipogenic.

If she just won't diet and oral therapy is indicated in adult-onset, nonketotic diabetes...

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lowers blood sugar without raising blood insulin.

For complete details, including dosage, please read the prescribing information. It's summarized below.

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dications: Stable adult diabetes mellitus; sulfonyl-ea failures, primary and secondary; adjunct to sulin therapy of unstable diabetes mellitus. *ntraindications:* Diabetes mellitus that can be gulated by diet alone; juvenile diabetes mellitus at is uncomplicated and well regulated on in-lin; acute complications of diabetes mellitus etabolic acidosis, coma, infection, gangrene); ring or immediately after surgery where insulin indispensable; severe hepatic disease; renal dis-se with uremia; cardiovascular collapse (shock); er disease states associated with hypoxemia. *arnings:* Use during pregnancy is to be avoided. *ecautions:* 1. *Starvation Ketosis:* This must be ferentiated from "insulin lack" ketosis and is aracterized by ketonuria which, in spite of relatively normal blood and urine sugar, may result from excessive phenformin therapy, excessive insulin reduction, or insufficient carbohydrate intake. Adjust insulin dosage, lower phenformin dosage, or supply carbohydrates to alleviate this state. **Do not give insulin without first checking blood and urine sugar.**
2. *Lactic Acidosis:* This drug is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, periodic determinations of ketones in the blood and urine should be made in diabetics previously stabilized on phenformin, or phenformin and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH, and the lactate-pyruvate ratio. The drug should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis.
3. *Hypoglycemia:* Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.
Adverse Reactions: Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake. (B) 98-146-103-E (6/72)

For complete details, including dosage, please see full prescribing information.

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What should a medication for sleep be expected to provide?

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psycholog dependence have not been reported c recommended doses, use caution in a ministering to addiction-prone individ or those who might increase dosage.

Precautions: In elderly and debilitate initial dosage should be limited to 15 r to preclude oversedation, dizziness a or ataxia. If combined with other drug having hypnotic or CNS-depressant effects, consider potential additive eff Employ usual precautions in patients who are severely depressed, or with

Sleep for 7 to 8 hours without need to repeat dosage during the night

No sleep medication has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia patients given one 30-mg capsule of Dalmane at bedtime, on average: fell asleep within 17 minutes, had fewer nighttime awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to repeat dosage during the night.

Sleep with consistency

Dalmane has been shown to be consistently effective even during consecutive nights of administration. Thus there is little likelihood for the need to increase dosage to maintain therapeutic effect.

Dalmane (flurazepam HCl) is a distinctive sleep medication—a benzodiazepine specifically indicated for insomnia. It is not a barbiturate or methaqualone, nor is it related chemically to any other available hypnotic.

Sleep with relative safety

Chronic tolerance studies have confirmed the relative safety of Dalmane; no depression of cardiac or respiratory function was noted in patients administered recommended or higher doses for as long as 90 consecutive nights. Dalmane is generally well tolerated and morning "hang-over" is relatively infrequent. Dizziness, drowsiness, lightheadedness and the like have been the side effects noted most frequently, particularly in elderly and debilitated patients. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

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depression or suicidal tendencies.
ic blood counts and liver and kid-
nction tests are advised during
ed therapy. Observe usual precau-
n presence of impaired renal or
c function.

se Reactions: Dizziness, drowsi-
ghtheadedness, staggering, ataxia
ling have occurred, particularly
rly or debilitated patients. Severe
on, lethargy, disorientation and
probably indicative of drug intoler-
r overdosage, have been reported.

Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

Opinion & Dialogue

"Prescription drugs – who should determine the maker?"

Dispenser of Medicine

Clifton J. Latiolais
President
American Pharmaceutical Association

"Too many doctors are indiffe ent to the economic consequences their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by forr AMA Chief Executive F. J. L. Blasingame, M.D.

Doctor, are you indifferent...?

In discussing an anticipated i crease in Blue Shield rates, Dr. Bla ingame's newsletter had this to say

"In general, it can be said, MI have given the impression they are not particularly concerned with the increase in cost of health care to th patients...

"True, an MD's training is primarily scientific, but in the real wo of practice, all of his scientific decisions have a price tag, or an econo impact. The economics of health c beckon the practitioner's attention Concern for economics of medicin

---

Maker of Medicine

C. Joseph Stetler
President
Pharmaceutical Manufacturers Association

When the pharmacist recommends that a drug product other th the one ordered be dispensed, the prescriber invariably permits the change when he feels the best inte ests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is ne sary for the prescriber to know tha the change is being contemplated, and to be in a position to consent c demur. Without that opportunity, t unilateral decision of the pharmac made in the absence of clinical kn edge of the patient, could expose h to needless risks, and in addition, jeopardize the relationship betwee the professions of Pharmacy and Medicine. In my view, there is noth in the pro-substitution argument t offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowle about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some deg puts him at a disadvantage. Most often, a practicing physician will n expert knowledge of no more than 5

Advertisement

ould be an obligation of medical actice...

"Medical societies ought to conct continuing campaigns to point t the substantial savings that could realized thru deductible insurance d protection for catastrophic illss. At the very least, they should, in e patients' interest, question the ctics of any insurance organization at raises health care costs by forcg policyholders to buy insurance ey may not need or want and probly won't ever use.

"Too many doctors are indiffert to the economic consequences of eir decisions. Too many, for exiple, habitually hospitalize patients the convenience of the MD. It's nsense to deny such habits exist...

"Doctors, thru their medical soties, have unhesitatingly appealed their patients for support in the ht against government interference h the private practice of medicine. d the public in the past has reonded. It's time the American Medl Association and state and local edical societies paid off the debt by cisive action to hold down the cost medical care."

st of Drugs

Insurance rates and hospital arges are only two factors in health care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists *are concerned.* Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

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30 drugs that he selects to treat the jority of conditions encountered in practice. Moreover, the physin's choice of a specific brand is sed on his knowledge of the pant's medical history and current ndition, and his experiences with particular manufacturer's oduct.

Some substitution proponents e argued that the dispensing of a escription is a simple two-party nsaction between the pharmacist d the patient, and that a substitut- pharmacist may avoid even a hnical breach of contract by simply ifying the patient that he is making substitution. I would judge that courts would be sympathetic ard a pharmacist who substituted hout physician approval and who dertook a legal defense that seeks nake the patient responsible for pharmacist's actions.

luced Prescription Prices?

Substitution advocates are ggesting to the consumer, and parularly the consumer activist, that luced prescription prices could ow legalization of substitution. have seen absolutely no evidence ustify this claim. To the contrary, erience in Alberta, Canada, where stitution is authorized, suggests the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advocates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

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P·M·A

108th MSMS Annual Session planning well underway: dates are Oct. 7-11, 1973

As the 1973 calendar year moves steadily along, the 108th MSMS Annual Session grows ever nearer. Scheduled Oct. 7-11 at the Sheraton-Cadillac Hotel, Detroit, the big five-day event is taking shape as the House of Delegates firms its schedule and the various specialty organizations plan their scientific meetings.

As in 1972, the 200-member MSMS House of Delegates will get the Annual Session underway Sunday evening, Oct. 7, beginning two and a half days of deliberations on key medical and socio-economic issues facing organized medicine in Michigan.

The deadline for resolutions to be submitted by MSMS members and component medical societies for discussion by the House is again 30 days before the house convenes, or Sept. 7. Those interested are urged to begin work now.

The deadline is already passed for nominations for 1973 Certificate of Commendation winners who will receive MSMS's highest tribute. The MSMS Committee, chaired by George Stilwill, MD, Lansing, is now at work selecting the top physicians from the nominations submitted by component societies.

Work also is underway to designate and contact those physicians who were graduated from medical school in 1923 and therefore are eligible for the MSMS 50-year award to be presented during House of Delegates ceremonies.

MSMS President-Elect Brooker L. Masters, MD, Fremont, will be installed in the final House of Delegates meeting, Tuesday evening, Oct. 9, and a new president-elect will be named, providing for the dramatic highlight of the three-day House meeting.

Then, on Wednesday and Thursday, Oct. 10-11, the scientific meetings will get underway in the Sheraton-Cadillac meeting rooms, free of charge to all MSMS members, interested medical students and health professionals.

In a major change of format, the 1973 Scientific Sessions will be planned and conducted by Michigan medical specialty societies, with financial and administrative assistance from MSMS.

Scientific Sessions program coordinator is John B. Bryan, MD, Royal Oak internist.

A full and impressive group of technical exhibitors have contracted to assemble their displays for viewing all day during both days of the scientific sessions. There will be approximately 40 exhibits to visit.

Finally, the preliminary schedule of meetings shows the following specialty organizations planning to meet. Physicians are urged to check their own specialties and make plans to attend on the days their programs will be held.

→

MSMS Annual Session to feature addresses by two governors

Gov. Milliken

Gov. Bowen

Two of the nation's governors—one Michigan's own and the other the only MD serving as a governor—will address portions of the 108th MSMS Annual Session Oct. 7-11 at the Sheraton-Cadillac Hotel, Detroit.

The governor of Ohio, The Hon. Otis R. Bowen, MD, will be the key speaker for the annual MDPAC Luncheon at noon Oct. 8 at the Sheraton-Cadillac Hotel. Approximately 250 Michigan physicians and their spouses are expected to hear Gov. Bowen, the only physician-governor in the U.S.

Gov. Bowen, a Republican, won his bid for governorship of his state in the 1972 fall election. He formerly served 12 years in his state legislature, and was Speaker of the Indiana House for six of those years. He is a graduate of the University of Indiana medical school.

The Hon. William G. Milliken, governor of Michigan, has accepted an invitation to address the MSMS House of Delegates on Tuesday, Oct. 9, on the status of health care in Michigan. Tentative plans call for him to have luncheon with key MSMS leaders on that day.

Detroit, the fast-growing convention center enjoying a renaissance of rebuilding, will draw approximately 2,000 MSMS members and interested conventioneers for the 1973 MSMS Annual Session, Oct. 7-11.

The Grand Ballroom of the Sheraton-Cadillac Hotel, Detroit, scene of the deliberations Oct. 7-9 of the MSMS House of Delegates and of some of the major meetings Oct. 10-11 of the Scientific Sessions, all a part of the 108th MSMS Annual Session.

Preliminary schedule of specialty meetings:

Wednesday, October 10

Section on Internal Medicine and the Michigan Society of Internal Medicine
Section on Ophthalmology
Section on Plastic Surgery and the Michigan Association of Plastic Surgeons
Section on Pediatrics
Section on Obstetrics-Gynecology and the Michgian Society of Obstetricians and Gynecologists
Section on Physical Medicine
Section on Urologv
Section on Gastroenterology and the Detroit Regional Gastroenterological Association
Section on Allergy and Applied Immunology and the Michigan Allergy Society
Section on Dermatology
Section on Proctology and the Michigan Proctological Society
Section on Otolaryngology and the Michigan Otolaryngological Society
Section on Occupational Medicine and the Michigan Industrial Medical Association
American Medical Writers, Detroit Chapter
Section on Orthopedic Surgery and The Michigan Orthopaedic Society

Thursday, October 11

Section on Surgery
Section on Pathology and the Michigan Society of Pathologists
Section on Public Health and Preventive Medicine
Section on Family and General Practice
Section on Thoracic Surgery and the Michigan Society of Thoracic Surgeons
Section on Radiology and the Michigan Radiological Society
Section on Neurological Surgery
  Michigan Chapter, American College of Chest Physicians
Section on Psychiatry

Because of conflicting national meetings, there will not be meetings of the Section on Anesthesiology and the Section on Neurology.

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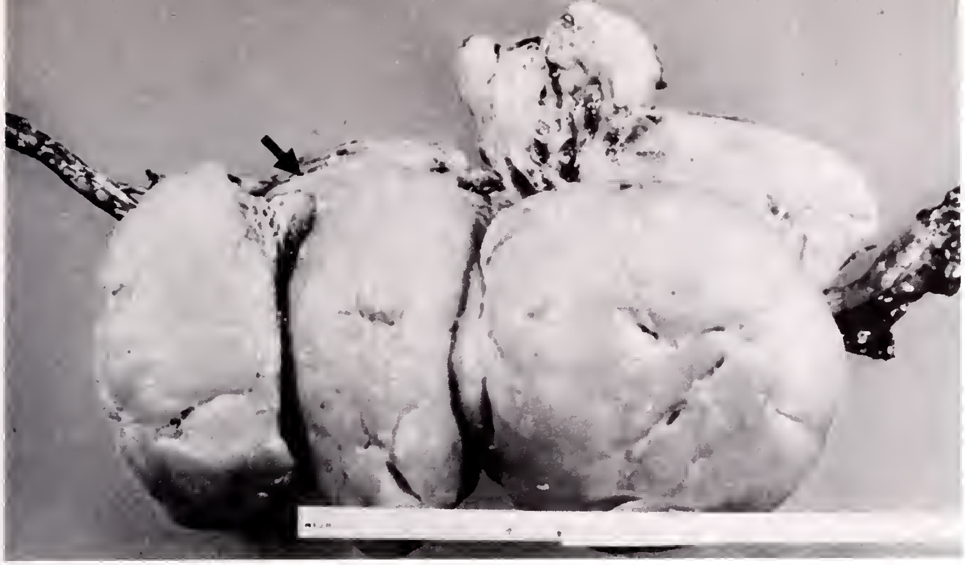

Fig. 1. Case 1. Bisected hysterectomy specimen with attached fallopian tubes. A bulging, lobulated lipoma of the fundus compresses the endometrial cavity (arrow).

Lipoma of the uterus

By Peter C. Dyke, MD
Ivars Zadvinskis, MD
Richard M. Wilcox, MD
Dugald S. MacIntyre, MD
Grand Rapids

Lipomas, adipose tumors found in many parts of the body, rarely present in the female genital tract, including the uterus.[1] Uterine lipomas, classified as "pure" or "mixed" on the basis of the absence or presence, respectively, of neoplastic muscle and fibrous tissue in addition to fat,[2] are exceedingly rare. Brandfass found only 33 cases of pure lipoma of the uterus reported to 1955.[2] His case[2] and that of Sabbagh[3] brought the number to 35. Since then, only three additional cases have been noted in the English language literature.[1,4,5] Most have consisted of case reports, only Henriksen[6] and Thaler[7] reporting multiple cases. This rare tumor, though well documented,[8,9] is often unrecognized.[10,11] Therefore, our experience with two cases is presented and a new theory of pathogenesis proposed.

Case 1

A 62 year old woman with acute right lower quadrant abdominal pain underwent laparotomy for suspected acute appendicitis. The appendix was unremarkable but the uterus was noted to be uniformly enlarged. A subsequent dilatation and curettage revealed endometrial hyperplasia. Hysterectomy with bilateral salpingectomy was performed.

Pathologic examination revealed a uniformly enlarged, 279 gram, 109x89x68mm. uterus with a globular fundus. On sectioning there is an anterior, intramural, 71mm. diameter, bulging yellow tumor with infrequent, delicate fibrovascular trabeculae. The thin, uniformly smooth endometrium is laterally displaced, reducing the endometrial cavity to a cleft. The cervix is preserved **(Fig. 1)**. Microscopic examination and fat stains reveal the well circumscribed interstitial tumor to be composed of mature, typical fat cells with no heterologous elements such as muscle or fibrous tissue. Foci of moderate endometrial hyperplasia are present and the fallopian tubes are preserved.

Case 2

A 48 year old woman with stress incontinence was noted on pelvic examination to have a right adnexal mass. Hysterectomy and bilateral salpingoophorectomy were performed. The right parovarian tumor consists of an 84 gram, 65x54x49mm. thin-walled, unilocular simple cyst. The 62 gram, 64x41x32mm. uterus is unremarkable except for an anterior, yellow-tan, finely lobulated, firm 7x6x4mm. tumor elevating the serosa. Microscopic examination and fat stains reveal a typical lipoma without heterologous elements **(Fig.**

Scientific articles

Doctor Dyke is chief of surgical pathology at Bishop Clarkson Memorial Hospital, Omaha, Neb. He formerly was associate pathologist at Blodgett Memorial Hospital in Grand Rapids, where Doctor Zadvinskis and Doctor Wilcox are residents in surgery. Doctor MacIntyre is senior attending surgeon and chairman, Department of Surgery, Blodgett Memorial.

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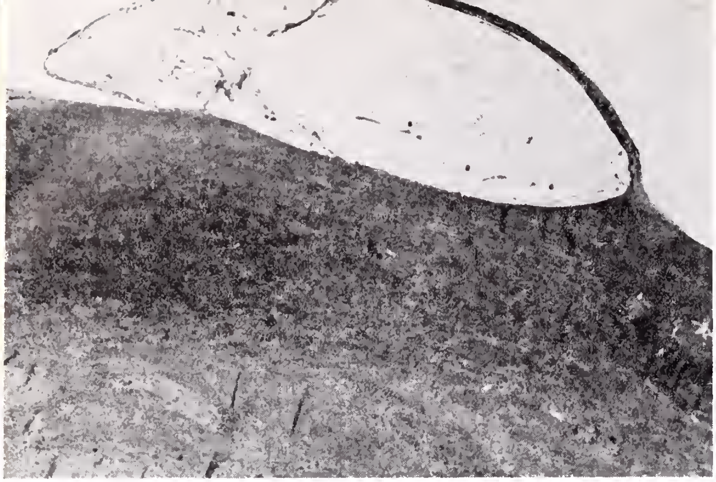

Fig. 2. Case 2. Whole section mount of anterior subserosal lipoma. Heterologous elements are absent.

2). Endometrium is proliferative, ovaries atrophic, and fallopian tubes unremarkable.

Discussion

The rarity of pure lipoma of the uterus is manifested by the fact that a review of 7,560 cases of uterine tumors by Ellis revealed only four examples.[5] Brandfass found that the ratio of "pure" to "mixed" tumors is about 1:2.[2] Since then, an additional case of mixed lipoma has been reported.[12] About 88% are in the corpus and the ratio of interstitial: subserosal: submucosal locations is 3:1:1.[2] Our two cases represent tumors of the fundus, one intramural, the other subserosal.

This is a disease of the elderly, most cases occurring in post-menopausal women,[2,4,12] as with our two cases. Diagnosis never has been made preoperatively. Its significance is fourfold: 1.) larger tumors on a geographical basis may mechanically interfere with neighboring organ function, 2.) the unwary surgeon may mistake this uterine tumor, similar to leiomyoma except for its often striking softness and yellow appearance, for leiomyosarcoma, 3.) malignant transformation to liposarcoma has not been reported,[12] and 4.) instances of rare, atypical tumors may someday contribute insights into mechanisms of neoplasia.

The histogenesis of lipoma of the uterus is completely unknown. Postulated mechanisms have included: misplaced embryonic fat cells, metaplasia of muscle or connective tissue cells, lipid infiltration of connective tissue, displacement of embryonic rests along the Wolffian duct, proliferation of initially subserosal fat derived from neighboring fatty tissue, and origin from scanty perivascular adipose tissue accompanying vessels into the uterus.[1] The fact that these tumors develop as mixed as well as pure lipomas makes us favor the possibility that their histogenesis involves neoplasia of multipotential mesenchyme within the myometrial interstitial connective tissue. This would explain the variable locations as well as variable components. The onset of tumor development, usually in older patients, could correspond to the development of less effective immune surveillance mechanisms that may occur with aging, this latter now evolving as a fundamental principle in the development of other tumor systems.[13]

Conclusion

Our experience with two cases of lipoma of the uterus and a study of the reported literature leads us to conclude that the most attractive possibility of histogenesis involves origin from multipotential interstitial mesenchyme, possibly stimulated to tumor formation by decreased immune surveillance accompanying aging.

Abstract

Two cases of the rare tumor, pure lipoma of the uterus, are reported. Previously recorded cases are briefly reviewed and possible mechanisms of histogenesis discussed. The pathogenic mechanism of neoplasia of multipotential interstitial mesenchyme, possibly triggered by decreased immune surveillance accompanying aging, is proposed.

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Cardiopulmonary Resuscitation in a community hospital—a one year experience

By Merle L. Dykema, MD
C. Mark Vasu, MD
Grand Rapids

Introduction

In 1960, closed chest cardiac massage was introduced by Kowenhoven, Jude and Knickerbocker[6]. In addition, the use of external cardiac defibrillation, the institution of training programs in CPR and the development of coronary care units has greatly improved the success of cardiopulmonary resuscitation.

Butterworth Hospital, a 450 bed community teaching hospital, has had an active cardiopulmonary resuscitation program for the past 10 years. This program of training is under the guidance of several attending physicians and includes training of all house staff, and all new nursing personnel. Refresher courses for attending physicians and nursing personnel are given frequently every year.

This report reviews the cardiopulmonary resuscitation experience at Butterworth Hospital from February 1971-January 1972 and compares our results with other studies.

Methods

When a cardiac arrest occurs the operator is notified and pages a "stat arrest" and gives the location of the arrest. Before the medical team arrives the nuring personnel begin external cardiac massage and ventilation. They may even institute defibrillation if the arrest occurs in the Intensive Care Unit or the Emergency Room depending on the location of the arrest. The medical resident who arrives on the scene first is in charge of interpreting electrocardiograms, directing other personnel present and selecting appropriate medications to be given. Ideally no more than five people are needed to carry out cardiopulmonary resuscitation. These include: inhalation therapist, three physicians and a nurse.

Data for this study were obtained primarily from log sheets which were compiled at the end of each resuscitation attempt by the charge nurse. Associated disease states, age of patient, location and time of the arrest were tabulated. Any additional information was obtained by reviewing the patient's hospital chart.

Survivors were grouped into either long-term or short-term. A long-term survivor is defined as a patient who was successfully resuscitated and was discharged from the hospital. A short-term survivor is a patient who survived an arrest but died while in the hospital.

Results

During the one-year period studied, a total of 212 patients underwent a total of 233 cardiopulmonary resuscitation attempts. If a patient had more than one arrest, each resuscitation attempt was counted as a separate entity. Of the 233 cardiopulmonary resuscitation attempts there were 97 successes or 41%. By successful is meant restoration to a prearrest state. This does not imply long-term survival.

Associated Disease

As is evident from **Table I** at least 90 patients (43%) suffered some form of cardiac disease. The number is probably larger considering that a significant number of the 45 patients who arrested at home, in the ambulance, or in the emergency room and died probably had some form of cardiac disease. Of these 90 patients there were 49 who suffered a myocardial infarction as the cause of the arrest. Of these 49 there were 16 short-term survivors (33%) and only four long-term survivors (8%). **(Table 2)**

In the group of patients with non-cardiac disease, major illnesses included cancer, pulmonary disease, accidental injuries, diabetic ketoacidosis and cerebral vascular accidents. None of these illnesses exceeded 5% of the overall number of patients who were resuscitated.

Patient Age

Age distribution is tabulated in **Table 3.** Fifty-six percent of patients were 60 years or older. The largest number of arrests occurred in the 60-69 year age group. Of the long-term survivors most were in the 50-70 year age group.

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Doctor Dykema was senior resident in internal medicine at Grand Rapids' Butterworth Hospital, where Doctor Vasu is director of the Coronary-Intensive care unit. Doctor Dykema is now stationed with the U.S. Army at Kenner Army Hospital, Fort Lee, Va.

Table 1
Primary Diagnosis In 212 Patients With Cardiac Arrest and Results

Disease	Number of Patients	Number of Arrests	Successful CPR
Myocardial Infarction	49	58	33 (57%)
Carcinoma	11	11	3 (27%)
Congestive failure	18	20	7 (35%)
Pulmonary embolism	3	3	1 (33%)
Open Heart Surg.	10	13	7 (54%)
Respiratory failure	6	6	4 (67%)
Heart block	7	7	5 (72%)
Post operative	8	8	4 (50%)
Accidental injury	10	10	1 (10%)
Coronary Arteriography	3	3	3 (100%)
Miscellaneous*	87	94	29 (31%)
Total	212	233	97 (41%)

*Miscellaneous includes: Patients who arrested at home, en route to hospital or in ER (45), GI bleeding (1), CVA (6), epiglottitis (2), fractured hip (3), pneumonia (4), septicemia (2), renal failure (2), diabetic acidosis (7), abdominal aneurysm (3), newborn (2), overdose (5), brain tumor (1), hypertensive crisis (1), liver failure (1), drowning (2).

Table 2
Survivors of Arrest In Acute Myocardial Infarction

Number of Patients	Short-Term Survivors*	Long-Term Survivors*
49	16 (33%)	4 (8%)

*Short-term defined as a patient who survived an arrest but died while in hospital.
Long-Term defined as a patient who was discharged from hospital.

Time of Arrest

An analysis of the time the arrests were called is shown in **Table 4.** Poorest results were obtained during the 11 P.M. to 7 A.M. shift. The results during the 7 A.M. to 3 P.M. and 3 P.M. to 11 P.M. shifts were about equal; however, most arrests were called during the day shift.

Location of Arrest

Table 5 shows data pertaining to the location of cardiac arrests. Sixty percent of resuscitation attempts were made on non-intensive care patients. There was no appreciable difference in percentage of successful resuscitation attempts on patients who were on the wards or in the emergency room. There was, however, a higher percentage of successful resuscitation attempts on patients in specialized care units, i.e. ICU, Cath Lab, Operating Room.

Survivors

The overall results of the cardiopulmonary resuscitation program at Butterworth Hospital during a one year period are shown in **Table 6.** Of the 212 patients who underwent cardiopulmonary resuscitation there were 37 short-term survivors (17%), 31 long-term survivors (15%) and 144 failures (67%). Of the long-term survivors all were discharged in their pre-arrest state and none suffered any neurological damage.

Discussion

Analysis of a one year period of cardiopulmonary resuscitation at Butterworth Hospital reveals that the results are comparable to those reported

Table 3
Age Distribution and CPR Results

Age	Number of Patients	Number of Arrests	Successful CPR
Below 30	22	23	11 (48%)
30-39	10	11	5 (45%)
40-49	20	20	9 (45%)
50-59	29	36	25 (70%)
60-69	53	60	31 (52%)
70-79	32	34	10 (29%)
80 and above	17	20	11 (55%)

Table 4
Time of Cardiac Arrests and Results

Time	Number of Arrests	Successful CPR
7 a.m.-3 p.m.	100	45 (45%)
3 p.m.-11 p.m.	81	38 (47%)
11 p.m.-7 a.m.	52	14 (27%)

Table 5
Location of Arrests and Results

Site	Number of Patients	Number of Arrests	Successful CPR
ICU	74	88	42 (48%)
Wards	51	51	18 (35%)
E.R.	60	60	20 (33%)
O.R.	8	8	5 (62%)
Peds	7	8	4 (50%)
Cath Lab	6	6	6 (100%)

Table 6
Overall Results of CPR at
Butterworth Hospital From
Feb. 1971 — Jan. 1972

#Pts.	Short-Term Survivors	Long-Term Survivors	Failures
212	37 (17%)	31 (15%)	144 (67%)

from university and community hospitals throughout the country **(Table 7)**. It is noteworthy that Butterworth Hospital has the largest series in a one year period. This may reflect an overzealous approach to cardiopulmonary resuscitation. If one looks at associated disease states there were 11 patients with carcinoma, six patients with cerebral vascular accidents and several very serious injuries with gross evidence of severe brain damage who, had they been successfully resuscitated, would have lived a decerebrate existence. To prevent unnecessary attempts at cardiopulmonary resuscitation Butterworth Hospital has adopted a policy of putting patients on either the seriously ill list (SIL) or the critically ill list (CIL). If a patient is placed on the former the nursing personnel know that no heroic attempts are to be made on that patient's life. The concept of the "sudden unexpected death" is stressed to avoid, if possible, an unncessary resuscitation attempt.

That there were only 8% long-term survivors in patients with myocardial infarction is somewhat disturbing. This is considerably lower than other studies have shown [2,3,4] . Of the short-term survivors with myocardial infarction most of them died because of an arrhythmia. The trend at Butterworth Hospital is not to use prophylactic antiarrhythmic drugs on patients with myocardial infarction. Fowler et al have shown, in a well designed and well controlled study, that the use of quinidine for prophylaxis of arrhythmias in acute myocardial infarction can reduce the incidence of ventricular and supraventricular premature contractions by 50%[1]. We have adopted a new stablization program at Butterworth which makes it mandatory that any patient who has suffered a myocardial infarction and is evaluated in the emergency room prior to going to the Intensive Care Unit receive a bolus of 50 mg. of Lidocaine. This patient must also be monitored by a portable monitor enroute to the Intensive Care Unit and must be accompanied by a house officer.

In our overall study no significant conclusions can be drawn concerning the age of the patient other than most of the long-term survivors were in the 50-70 year age group. The reason the younger age groups didn't fare better is that more serious associated disease states were generally present in the younger age groups. It is noteworthy that there was a significant number of successful resuscitation attempts in the 80 year old and above group. However, there was only one long-term survivor in this group.

It is not surprising that the poorest results were obtained on the 11 P.M. to 7 A.M. shift. Several things can account for this: 1) decreased number of nurses on duty, 2) less surveillance of the patient, especially those on the wards, and 3) a reduced number of house staff.

The data concerning location of arrest reveals that the best results were obtained in areas where special equipment was immediately available, i.e. ICU, O.R., Cath Lab. The reason for poorer than expected results in the Emergency Room, where

Table 7
Comparative Results of CPR

Hospital	Years	Number of Patients	Long-Term Survivors
Butterworth	1	212	31 (15%)
Toronto Gen.	1	184	19 (10%)
St. Joe, Calif.	5	460	101 (22%)
U. Virginia	4	368	30 (8%)
Sinai, Detroit	2	98	16 (16%)
Royal Victoria	10	1204	230 (19%)
Buffalo Gen.	9 mo.	123	9 (8%)

special equipment is also available, is probably because of the very serious condition of the patient prior to arrival in the Emergency Room.

For many years cardiopulmonary resuscitation classes have been held for all rescue personnel which includes policemen, firemen and ambulance attendants. If they arrive at the scene quickly enough they begin CPR and usually most effectively. Survival from ventricular fibrillation, the most common arrhythmia causing a cardiac arrest, is time dependent on defibrillation. One can expect a lower survival from the "on the street" cardiac arrest even with well-trained personnel doing cardiopulmonary resuscitation.

We will soon start telemetry of EKG's to base hospitals in our area which will allow rescue personnel to defibrillate at the scene. We hope this will improve survival.

Our results agree with Hollingsworth[4] who found that a patient who suffered a severe neurologic deficit rarely survived the 24 hour period after the emergency and none survived long enough to be discharged. All of our 31 long-term survivors suffered no neurological damage.

INFORMATION FOR CONTRIBUTORS

1. Address scientific manuscripts to the Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Submit original, double-spaced typewritten copy and two carbon copies or photo copies on letter size (8½ x 11 inch) paper. On page one, include title, authors, degrees, academic titles, and any institutional or other credits.

2. Authors are responsible for all statements, methods, and conclusions. These may or may not be in harmony with the views of the Editorial Staff. It is hoped that authors may have as wide a latitude as space available and general policy will permit. The Publication Committee expressly reserves the right to alter or reject any manuscript, or any contribution, whether solicited or not.

3. Illustrations should be submitted in the form of glossy prints or original sketches from which reproductions will be made by **Michigan Medicine.**

4. Articles should ordinarily be less than four printed pages in length (3000 words).

5. References should conform to *Cumulative Index Medicus,* including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.

6. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.

7. It is understood that material is submitted for exclusive publication in **Michigan Medicine.**

8. Letters and articles for the news section should be sent to the Managing Editor, **Michigan Medicine**, 120 W. Saginaw, East Lansing, 48823, by the fifth of the month preceding the month of publication.

Conclusion

Lemire and Johnson[7] have shown that a cardiac resuscitation service can save one out of five patients undergoing resuscitation. While our results may not quite agree with theirs we would agree that CPR is worthwhile. A major problem in CPR is the tendency to attempt resuscitation in patients with debilitating and end stage disease. We hope our system of putting patients either on the seriously ill list or critically ill list will help solve this problem.

Another difficult problem is physician education and knowledge with reference to CPR techniques. Compulsory physician education programs are not now being utilized but in light of recent legal implications it behooves each physician, no matter what specialty he represents, to be well versed in the techniques of CPR.

Appreciation is expressed to Mrs. Candice Otto, RN for her assistance in the organization of the large amount of data and to Miss Amanda Stressman for the technical preparation of this paper.

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Tuberculosis: why our concepts have changed

By Philip G. Cramer, MD
Eloise

The article "Tuberculosis — Changing Concepts" in the December 1972 issue of *Michigan Medicine* is deserving of comment from someone representing the opposite viewpoint. As a physician deeply involved in a tuberculosis control program with nearly total emphasis on out-patient care, I feel that the concepts on which our treatment is based are much more scientifically grounded than the article by Doctor Koop would lead us to believe.

His viewpoint is shared by many (perhaps most) of the physicians who were the medical directors of tuberculosis sanatoriums. In an editorial in *Tuberculosis*, the publication of the International Union Against Tuberculosis, away back in 1965, we read:

> "The committee noted that similar controlled comparisons of bed rest and ambulation and of domiciliary and institutional treatment carried out in technically advanced countries also did not indicate any superiority of institutional over ambulatory treatment. It emphasized that the application of these results could lead to impressive economic savings in national tuberculosis programs. In this situation, the Committee felt that it was incumbent on those advocating the superiority of institutional treatment to conduct studies to determine whether their contention is substantiated by objective evidence."

The scientific rationale to treat tuberculosis patients in an ambulatory fashion was actually available to us in 1960:

1. The effectiveness of INH and PAS to convert the sputums of patients with tuberculosis over 90% of the time had been demonstrated by numerous investigators. The drug Isoniazid is the foundation on which our changing concepts in tuberculosis all are based. The introduction of this drug rivals vaccination and penicillin in importance to therapy or prevention of human disease.
2. Wier, et al.,[2] showed that patients with tuberculosis kept at bed rest did no better than a similar group on an exercise program when both were given the same chemotherapy.
3. The Madras Group,[3] who contributed so much to our knowledge of the chemotherapy of tuberculosis, showed that the initimate contacts of patients *never* hospitalized, treated with INH and PAS, had no more skin test conversions when tested one year later than the contacts of a similar group also treated with INH and PAS but kept hospitalized until their sputum was negative. [This has never been done in this country, therefore the pamphlet distributed by the American Thoracic Society, "Bacteriologic Standards for the Discharge of Patients," must state (as Dr. Koop puts in capital letters), THERE IS STILL NO SOLID EXPERIENCE IN THIS COUNTRY THAT PROVES THIS IS SO. However, a really good study has not and cannot be done here; would it be humane to take patients 50 and more pounds below their normal weight who are literally carried into the hospital by their families and send them home without hospitalization? To make a good control group, this would *have* to be done].

Table I. Changes in Approach to Treatment

	1965		1971 1st 6 months	
Total cases	261		128	
Average cumulative days hospitalization, 1st year	299		85	
Still hospitalized at one Year	114	(44%)	3	(2.3%)
Resectional Surgery	83	(32%)	2	(1.6%)

We instituted our out-patient program in Detroit in January of 1971. **Table I** shows our first six months of experience contrasted with the experience of the full year 1965. Despite the greatly shortened hospital period, after one year of chemotherapy, the percentage of patients whose sputum had converted was almost exactly the same **(Table II)**.

Only 26 of the 128 patients had a positive sputum after discharge; most of these were hospitalized very briefly (if at all) and most lived in homes where there usually was only a spouse, and hence were probably more isolated at home than they would have been in a hospital or sanatorium.

Long term contact follow-up is not available as yet, but, if our patients were spreading their dis-

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Doctor Cramer is assistant director of internal medicine, Wayne County Health Department, Division of Respiratory Disease Control, Detroit and Wayne County.

Table II. Status at one Year

	1965		1971	
Quiescent	213	(81.6%)	105	(82%)
Probably quiescent	18	(6.9%)	11	(8.6%)
Dead	9	(3.5%)	3	(2.3%)
Unsuccessful	17	(6.5%)	8	(6.3%)
Status Unknown	4	(1.5%)	1	(0.8%)

Definitions:

Quiescent — three negative sputum cultures more than 21 days apart after the last positive sputum, at least one of which had to be in the last three months of the year

Probably Quiescent — three negative sputum cultures more than 21 days apart after the last positive sputum, no observation available in the last three months of the year

Unsuccessful — three negative sputum cultures more than 21 days apart after the last positive sputum, not available yet

Status Unknown — lost more than six months of the year

Table III.
Total New Active Cases of Tuberculosis, Wayne County, Michigan

	Year	Cases
All in-patient chemotherapy:		
	1968	1023
	1969	777
	1970	833
Out-patient chemotherapy begins January, 1971		
	1971	745
	1972	644

ease, our total case rate should have gone up. One year after the institution of our program, the reverse had happened. **(Table III)**

Who spreads tuberculosis? Unfortunately, it is not the patient being treated for the disease, but, more often than not, it is the case we don't know about yet.

Out-patient chemotherapy saves us money, keeps our patients with their families, and returns them to work promptly. It hasn't solved the problem of the recalcitrant patient, but neither did locking him up.

I cannot in one short article hope to give an answer to every specific objection raised by the institutional treatment advocates, but I hope I have explained enough to make my point. Face out-patient chemotherapy with optimism, not pessimism. We certainly are in Detroit.

So you have tuberculosis. Stay in bed? Stay in the hospital?

What for? Go home! Forget you have tuberculosis (except 30 seconds per day; that's how long it takes to swallow your INH and Ethambutol).

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Perinatal tips

By Paul M. Zavell, MD
Detroit

The following case from the files of the Wayne County Medical Society Perinatal Mortality Committee is presented as an aid in continuing education.

Maternal

This was the first pregnancy for a 23 year old old white woman with O + blood type. She had been seen regularly at monthly prenatal visits from the second month of pregnancy on.

At 39 weeks she had the onset of mild abdominal cramps followed by painless vaginal spotting. During the next 12 hours the cramps increased and the spotting changed to intermittent light vaginal bleeding. After calling her obstetrician she went to the hospital for admission. Soon after admission she was examined by sterile vaginal exam and found to be only 1 cm dilated but well effaced.

With bed rest the cramps ceased but the intermittent mild bleeding persisted. Abdominal x-ray and placentogram showed the infant's head to be well down in the pelvis with no signs of placenta praevia.

Labor failed to become progressive despite alternate bed rest and I.V. Pitocin drip and finally artificial rupture of membranes. After a consultation, it was decided that a C-Section should be done rather than send her home.

However, before this could be done she started in true labor (after two and a half days in the hospital). Thirteen hours and 22 minutes later her son was born vaginally. She had gained only nine and three-quarter pounds during pregnancy. Studies done were initial Hgb of 12.1 gm with Hct of 37, and negative results for urinalysis, HAI Test and VDRL.

Fetal

This 7 lb. 6½ oz. white male infant appeared perfectly normal after birth. Cord blood was O+ with a negative Coombs.

The infant was examined soon after birth and the obstetrician made a point to notify the pediatrician of the difficulties he had had with the mother and birth of the child. The physical exam, however was normal.

Following his usual custom the pediatrician signed out the infant after this initial exam to "go home with mother when she goes." (He did not resee the infant until necessary to do so on the evening of the 4th day).

Until the morning of the 4th day all seemed normal. However, the infant was noted to be moderately jaundiced. The pediatrician was called and he then ordered by phone a bilirubin, which showed a total of 6.8 mgm % (only 0.6 mgm % direct). He felt this was physiologic influenced by breast feeding and proceeded to order glucose water q.i.d. between feedings. However, by that evening the temperature was noted to be subnormal (96.7° R) and could not be raised by external heat. Additionally mild but generalized cyanosis as well as gradual increasing of the respiratory rate to 60/minute was noted.

The pediatrician was called and did come in to see the infant. He noted "coryza, mild tonsillitis, voice fair, mild inspiratory retraction with fair aeration and a heart rate of 160." His diagnosis was "URI". He ordered a CBC (Hgb of 13.3 gm, Hct of 41, WBC of 19,416 with 69 PMN, 21 Lymph and 10 mono), Bilirubin (total of 7.6 mgm%), a throat culture, glucose (80) and stat portable chest x-ray ("Right Upper Lobe Bronchopneumonia with generalized increased density of the Right Lung"). He started the infant on Aq. Cryst. Penicillin 75,000 U q 12 h IM.

By the following morning the infant was having increased cyanosis and respiratory distress and the throat culture showed growth of both gram positive diplococci and gram negative rods (later shown to be pneumococcus and E. Coli). At this point Kanamycin 25 mgm IM q 12h was added. The infant did very poorly during the day so that he was transferred that evening to the N.I.C.U. at another hospital. Here the admission physical exam showed "pale appearance, some peri-orbital cyanosis, good femoral pulse, soft abdomen with liver 1½ fgb below RCM, lungs *clear* and RR of 90/min with heart rate of 160/m and no murmurs". Chest x-ray showed "Cardio-Thoracic Index of 0.66 with RUL Infiltrate". The diagnosis of "Pneumonitis with secondary Heart Failure" was made. An EKG was ordered but before it could be done the infant's condition became very grave. Despite bagging, intubation, being placed in the Bourner respirator and administration of I.V. 1.0 cc $NaHCO_3$ and 0.2 cc adrenalin IM followed by 0.2 cc

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Doctor Zavell is chairman, Neo-Natal and Hospital Care Committee, Michigan Chapter, A.A.P., and chairman, Perinatal Mortality Study Committee, Wayne County Medical Society.

adrenalin intracardially the infant expired. A post mortem was obtained that showed a congenital heart with a membranous ventricular septum and pulmonary valve agenesis as well as early right upper lobe pneumonia.

Perinatal Committee Comments

1. When it is deemed necessary to do a sterile vaginal exam it is extremely wise to have a "double setup" available so that if it should become necessary an emergency C-Section can be immediately performed.
2. The use of a consultant when considering whether or not to do an emergency C-Section is both wise and good obstetrics.
3. Although this is not always true, severe cramps associated with vaginal bleeding should be differentiated from only painless vaginal bleeding. There is more likelihood of abruptio placenta with the first and placental praevia or marginal sinus rupture with the second.
4. A moderate degree of jaundice on the fourth day in a full term breast fed infant with no blood incompatibility problems may well be only physiologic. However if the infant is lethargic, sucking poorly or febrile the possibility of infection should be considered.
5. The practice of seeing an infant initially and "signing him out" at this time with the idea of not reseeing him is an example of poor pediatric newborn care. Ideally the infant should be seen daily or at least every other day. If this is not possible at least phone conversations daily with the nurses should be held, remembering that the nurse is not a doctor and may not be able to detect early problems.
6. The obstetrician used good judgment in notifying the pediatrician of all the troubles he had had with the mother's pregnancy, labor and delivery. He should be commended.
7. The Committee felt 1.0 cc of $NaHCO_3$ I.V. was certainly an inadequate amount to use to try to aid respiratory distress here.
8. When an infant is seriously ill (or thought to be so) with infection he should be treated with antibiotics as if he has a sepsis (i.e. penicillin and kanamycin or some similar regimen). Using only penicillin may be in the Committee's opinion inadequate treatment.
9. Failure to raise the temperature despite efforts made in an infant subject to possible infection should alert one to this possibility.

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

MONTHLY SURVEILLANCE REPORT

CASES OF CERTAIN DISEASES REPORTED
TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH
For the five-week period ending June 1, 1973

	1973 This 5-Week Period	1972 Same 5-Week Period	1973 Total To Above Date	1972 Total Same Date	Total Cases for 1972
Rubella	474	296	1,387	1,071	1,460
Cong Rubella Syndrome	0	0	1	0	1
Measles	1,118	472	3,394	1,511	2,353
Whooping Cough	5	4	34	44	116
Diphtheria	0	0	0	1	1
Mumps	714	497	3,318	2,223	3,729
Scarlet Fever & Strep Sore Throat	2,199	1,233	11,784	6,629	13,304
Tetanus	0	1	0	1	2
Poliomyelitis (paralytic)	0	0	0	0	1
Hepatitis	381	421	1,694	1,974	4,322
Salmonellosis (other than S typhi)	52	84	250	310	781
Typhoid Fever (S typhi)	3	1	6	4	7
Shigellosis	66	47	237	216	574
Aseptic Meningitis	10	7	58	30	266
Encephalitis	20	8	64	33	108
Meningococcic Meningitis	8	7	26	27	55
H Influenza Meningitis	14	7	52	34	81
Tuberculosis	169	210	606	773	1,609
Syphilis	447	505	1,907	2,171	4,815
Gonorrhea	2,404	2,180	11,663	9,253	24,728

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, MD, Director
Michigan Department of Public Health

msms action

Members of the MSMS Committees on Public Relations and Legal Affairs were encouraged to continue and expand their educational programs about chiropractic when they met recently at MSMS headquarters for a joint workshop. Addressing them was Joseph A. Sabatier, Jr., MD, New Orleans, immediate past chairman of the AMA Committee on Quackery. Doctor Sabatier offered his own and the AMA's aid in conducting educational campaigns about chiropractic for physicians and the public.

Earlier in the day, the MSMS Committee on Public Relations, chaired by Thomas C. Payne, MD, Lansing, standing, reviewed the many current MSMS public relations efforts, among them the taped radio interview series, the new direct-dial "Medical Memo" information telephone system, and the slide story of MSMS activities. Reports were heard from the MSMS Auxiliary, medical assistants and component societies conducting successful public relations efforts.

Michigan schools delighted with MSMS offer

"It is quite likely we will turn to MSMS for assistance in a number of areas."

That comment is typical of many replies MSMS received from college and university officials in response to an MSMS letter "to offer its good offices in obtaining qualified instructors" for medical and health courses.

The quotation above is from a letter from U-M Medical School Dean John A. Gronvall, MD, who also added, "I do much appreciate this formal expression of willingness to help."

W. W. McKee, vice president of the Merrill-Palmer Institute, wrote, "We will take advantage of your offer . . . we heartily concur with your point on the importance of courses being taught by well qualified persons."

"Oakland University is planning to introduce a series of new offerings in the health science area and we will be pleased to take advantage of your generous offer to assist us in identifying talented teaching personnel. It is our intention to seek out the most highly qualified faculty available."

"We at Ferris are pleased to learn of the assistance and guidance offered by MSMS in seeking qualified instructional personnel," wrote A. L. Andrews, dean of the School of Health Sciences and Arts.

"We are planning to expand our offerings in the area of medical and paramedical programs . . . and certainly appreciate your offer to provide assistance and guidance," wrote W. R. Walworth of the Genesee Community College.

A specific request was made by one college for help in finding qualified faculty members for a nurse training program.

The resolution to offer MSMS assistance was introduced to the MSMS House of Delegates by Thomas J. Setter, MD, now president of the Macomb County Medical Society. The resolution observed that "Michigan universities, colleges, community colleges and some agencies are providing more and more credit and non-credit courses for medical and paramedical courses" and therefore MSMS should offer assistance in finding qualified teachers.

Lewis E. Simoni, MD, right, chairman of the MSMS Hospital Relations Committee, was general program chairman for the MSMS-MHA Forum held at Boyne Highlands. Here he confers with two speakers — Dennis R. Barry, left, Chapel Hill, N. C., and Robert Cadmus, MD, center, Milwaukee.

Doctor Wilson explains PSRO work at hospital meeting

The MSMS efforts to coordinate PSRO activites in the state were reviewed by John R. Wilson, MD, Grand Rapids, chairman of the MSMS ad hoc committee, at the Seventh Annual Medical Staff-Trustee-Administrator Forum.

Lewis E. Simoni, MD, Flint, chairman of the MSMS liaison committee with the Michigan Hospital Association, was general chairman for the Forum, which drew about 200.

Brooker L. Masters, MD, MSMS president-elect, represented MSMS at the conference banquet.

The importance of greater cooperation between the medical chief of staff, the hospital administrator and the hospital trustees was stressed by various speakers. The various pressures of government, planning bodies, consumer groups, etc., were reviewed.

A summary of the various speeches is available from Herbert A. Auer, Manager, MSMS Department of Communications, MSMS, 120 West Saginaw, East Lansing 48823.

MSMS actively welcoming new members

One of the current major directions of MSMS activity is toward attracting new members, to provide new vitality and continual growth in numbers for our active state society.

Toward that end, a number of efforts are underway to reach out toward the many foreign physicians arriving in Michigan as interns and residents, to contact practicing physicians who are not members of MSMS, to increase students', interns' and residents' contributions in medical society activities, and to improve services to new MSMS members.

In conjunction with these efforts, the MSMS Committee on Constitution and Bylaws is continuing its study of proposals for active membership of interns and residents.

In March, a mailing was made from MSMS headquarters to physicians practicing in Michigan who are not members of MSMS. From that group, MSMS was able to pass on to the appropriate county medical societies the names of 62 physicians who had never received an invitation to join MSMS and/or wanted to become MSMS members.

Follow-up telephone calls soon will be made to those 62 physicians. Approximately 40 are in Wayne and Washtenaw counties.

In March and again in April, MSMS staff members met with foreign trained physicians now practicing privately or on hospital staffs, to solicit their suggestions for ways that MSMS can better serve the foreign physician who ultimately is likely to become an MSMS member.

The major suggestion—there were six recommendations—was that MSMS first reach the newly-arrived foreign medical graduate (FMG) who is training in our hospitals.

As a result, a pilot program is being established in Genesee County, where meetings are being called with the directors of medical education at the three teaching hospitals, county medical society representatives, auxiliary members and foreign-trained physicians already in practice.

The goal is to help the hospitals set up a mutual program to orient the foreign physician to methods of medical care, organization of medical societies, management of medical practices, cultural, economic and social customs of the U.S.

Non-members receive periodic informational communications from MSMS. For example,

Mrs. Audrie Chute, CMA, Royal Oak, took over duties as president of the State of Michigan Branch, American Association of Medical Assistants, as MSMS President John J. Coury, MD, right, looked on. Passing on the gavel was Miss Margaret Broadwell, CMA, left, 1972-73 president.

Honored guests at the annual meeting of the medical assistants were Mrs. Edwin Knights, left, wife of the president-elect of the Oakland County Medical Society; Sidney Chapin, MD, president, Wayne County medical Society, and Mrs Louise Cole, vice president of the Michigan Branch, AAMA

Medical assistants install Mrs. Chute; make awards

Winners of awards for their local societies' bulletins were from left, Florence Mannion, Kalamazoo; Marjorie Flintoft, awards chairman for the state organization; Sharon Caughel, St. Clair County; Sandra McGill, Jackson County, and Rita LePard, Genesee County.

NEW MEMBERS/Continued

MSMS recently sent them a reprint of a special *Michigan Medicine* article on MSMS efforts to comply with the new federal legislation requiring establishment of Professional Standards Review Organizations.

Non-members, including interns, residents and FMGs took part in an important MSMS Planning and Priorities Committee meeting June 13 in which they were given an opportunity to describe goals they believe MSMS should be setting.

And, finally, new members of MSMS are mailed a complete informational packet describing the MSMS benefits available to them—*Michigan Medicine*, the six insurance programs, the car leasing program and ski club and the structure of MSMS itself.

Here are 1973 Michigan locations for students in SAMA-MECO project

During these summer months, 105 medical students are learning about community medical practice while spending eight to 10 weeks under the supervision of practicing physicians in Michigan hospitals.

The students, most between their first and second years of medical school, are participating in the Student American Medical Association Project for Medical Education and Community Orientation. This is the fourth year of MSMS coordination of the Michigan phase of the national project.

There are currently 40 participants in Michigan hospitals from Wayne State University, 40 from the University of Michigan Medical School, 20 from the MSU College of Human Medicine, one each from the Chicago College of Osteopathic Medicine, Northwestern University Medical School and the Georgetown University School of Medicine and one 1973 graudate of MSU who will enter the U-M Medical School in August.

MSMS participation is under the direction of its Education Liaison Committee, with Brock E. Brush, MD, Detroit, chairman. The Michigan student coordinator is R. William Holden, WSU School of Medicine. Further information may be obtained from the MSMS Department of Communication, 120 W. Saginaw St., East Lansing, 48823.

Town and Hospital	Physician Program Director	Administrator	Student and School	Home Town and County
ALBION Comm Hosp	Miriam Daly, MD Ralph Cram, MD	O.D West, MHA	Mason Cobb (MSU)	Saranac, Ionia
ALLEGAN Gen Hosp.	H.E. Schneiter, MD	Charles H Yeates	Donald G Hill (WSU)	Byron Center, Kent
ALPENA Gen Hosp.	F C O'Dell, Jr., MD	Richard Hill	Richard Freese (U-M)	Detroit, Wayne
BATTLE CREEK, Comm Hosp	Alfred Hamady, MD	Walter Bell	Marilyn Terranella (MSU) Susan K Stauffer (U-M) Inaam Hamama (WSU)	Battle Creek, Calhoun Battle Creek, Calhoun Oak Park, Oakland
Leila Y Post Montgomery Hosp	John J Girardot, MD	Sr Mary Charlene Curl, RSM	Alfred J Guerrero (U-M) Nathan Jackson (WSU) Daryl Larke (Northwestern)	Wayne, Wayne Birmingham, Oakland Battle Creek, Calhoun
BAY CITY, Bay Medical Center	Paul W Rowe, MD	Louis Furlong	Victoria Nessel (U-M) Ahmad Ghandour (WSU) Susan Ghandour (WSU) Lorenz Kielhorn (MSU) David A Wood (U-M) Sharon Esau (WSU) Gary Herzler (WSU) John Putman, Jr (Chi Coll of Osteopatic Medicine)	Detroit, Wayne Detroit, Wayne Detroit, Wayne Grandville, Kent Bay City, Bay Wyandotte, Wayne Saginaw, Saginaw Detroit, Wayne
CADILLAC, Mercy Hosp	Kenneth Kleyn, MD	Sr Mary Ricardo, RSM	Robert Mosenfelder (U-M) Brian Campbell (WSU) Thomas Doyle (MSU)	Escanaba, Delta St Johns, Clinton Livonia, Wayne
DETROIT, Alexander Blain Hosp	Alexander Blain, III, MD	John Staub	Allen Ford (WSU) James Stewart (WSU)	Detroit, Wayne Charlevoix, Charlevoix
EATON RAPIDS, Comm Hosp	Eber Sherman, MD	John E Williams	Mark Meengs (MSU)	Zeeland, Ottawa
EDMORE, Tri-County Comm	Medical Staff	Kenneth Meade	Dennis Molinari (WSU)	New York City
ESCANABA, St Francis Hosp	Roland Berry, MD	Sr Cleophae	James E DeBoer (U-M)	Grand Rapids, Kent
FLINT, McLaren Gen Hosp	Nancy Furstenberg, MD	William Werdel	Jim Orosz (WSU) Ronald Falit (WSU) Paul Braman (WSU) Mark Jacobstein (U-M) Keith A Keck (U-M) Bruce Steffes (U-M) Kathryn Schmale (U-M) Ronald Pelavin (WSU) Karin Tansek (MSU) Christine Veres (MSU)	Flint, Genesee New York City Detroit, Wayne Oak Park, Oakland Elsie, Clinton Lapeer, Lapeer Bloomfield Hills, Oakland Oak Park, Oakland Bloomfield Hills Detroit, Wayne
FRANKFORT, Paul Oliver Mem. Hosp	Gordon Willoughby, MD	Bruce C Huron	Herbert K Foresman III (U-M)	Grand Blanc, Genesee
FREMONT, Gerber Mem Hosp	Robert E Paxton, MD	Dwight Austin	Robert LaPenna (MSU)	Grand Rapids, Kent
GAYLORD, Otsego Co Mem Hosp	Wm. Trowbridge, MD	Howard Purcell	Conley Engstrom (WSU)	Dearborn, Wayne
GLADWIN Area Hosp	Sambamurti Srinivasan, MD	Patrick Monaghan	Arve Gillette (U-M)	Montgomery, Hillsdale
GRAYLING, Mercy Hosp	Donald Burkley, MD	Sr Mary Hilda, RSM	Charles Gosling (U-M)	Kalkaska, Kalkaska
GREENVILLE, United Mem Hosp	Charles Stevens, MD	Joseph Dascola	Richard Schneider (WSU)	Birmingham, Oakland

GROSSE POINTE, Cottage Hosp	Walter Kujawski, MD	Ralph Wilgarde	Robert Bitterman (WSU)	St Clair Shores, Macomb
			Gary Enzmann (U-M)	Grosse Pointe, Wayne
HANCOCK, St. Joseph's Comm Hosp	Forrest Larson, MD	Sr Jean Francis Haug, CSJ	Mark Shebuski (U-M)	Houghton, Houghton
			James Harrison (U-M)	Crystal Falls, Iron
HART, Oceana Hosp.	J M Holbrook, MD	Dean Gustafson	Sander Drent (U-M)	Detroit, Wayne
HASTINGS, Pennock Hosp.	Larry Blair, MD	Richard Fluke	Lee O Stuart (MSU)	Portland, Ionia
HILLSDALE, Comm. Health Center	Charles Vear, MD	Dempster Muffitt	John K Sullivan (Georgetown)	Jackson, Jackson
			Larry J Fowler (WSU)	Jonesville, Hillsdale
HOLLAND City Hosp.	Carl VanKrimpen, MD	Frederick Burd	Craig Bade (WSU)	Holland, Ottawa
			Bruce Day (MSU)	Kalamazoo, Kalamazoo
IRON MT, Dickinson Co Mem Hosp	Robert Anderson, MD	Lowell Swanson	Bruce Main (U-M)	Goshen, Ind.
IRONWOOD, Grand View Hosp	Florian Santini, MD	Frank Drazkowski	Roman Glamb (U-M)	Detroit, Wayne
LAKEVIEW, Kelsey Mem Hosp	W B Bennett, MD	Bernard Kirshman	Andris Kazmers (WSU)	Lakeview, Montcalm
MANISTEE West Shore Hosp	Robert Garneau, MD	Robert Trautman	Carolyn Hokanson (WSU)	Manistee, Manistee
MANISTIQUE, Schoolcraft Memorial Hosp	Larry J Sell, MD	Ronald Czarneke	Robert Jean (MSU)	Nadeau, Menominee
			Robert McNutt (MSU)	Swartz Creek, Genesee
MARLETTE Comm Hosp	Raymond J Winfield, MD	Frederick W Spaven	Robert Hamilton (U-M)	Birmingham, Oakland
MARQUETTE, St Luke's Hosp	J Michael Coyne, MD	R P Gilstrap	Marc Meisner (U-M)	Huntington Wds, Oakland
St Mary's Hosp	Robert Berry MD	R P Gilstrap	Gary E Nichols (U-M)	Deerton, Alger
MARSHALL Oaklawn Hosp	Jules Netreba, MD	Avon Kierstead	David Lambrix, Jr (U-M)	Riverview, Wayne
MASON General Hosp	George R Clinton, MD	Robert A Recher	Malonnie Kinnison (U-M)	Mason, Ingham
MT CLEMENS, St Joseph	Alberto Cohen, MD	Sr Anna Suttman, SC	Gary E Leach (WSU)	St Clair Shores
			John M Coffey (WSU)	Dowagiac, Cass
MUSKEGON Hackley Hosp	A A Aardema MD	Don W Snyder	Larry Steigelman (U-M)	Muskegon, Muskegon
			Oksana Baltarowich (WSU)	Detroit, Wayne
			Kenneth Lane (MSU)	River Rouge, Wayne
Mercy Hosp	I J Kleaveland, MD	Sr Mary Naomi, RSM	Mark Knapp (WSU)	Westland, Wayne
			Peter Bozeman (U-M)	Muskegon, Muskegon
NILES Pawating Hosp	John Doolittle, MD	Mrs Jane Davis	Albert Yee (U-M)	Southfield, Oakland
			Vance V Van Drake, Jr (WSU)	Niles, Berrien
NORTHPORT Leelanau Mem Hosp	Dwight Schroeder, MD	Kathleen Putnam	William Shaffer (U-M)	Taylor, Wayne
PETOSKEY, Little Traverse Hosp (with Charlevoix Hosp Cooperating)	Jean H Webster, MD	John Rasmussen	Erin Arvilla (MSU)	Charlevoix, Charlevoix
			Ellen Arvilla (MSU)	Charlevoix, Charlevoix
			Herbert Hamel Jr (MSU)	St Ignace, Mackinac
			Michael Ptasnik (MSU)	Cheboygan, Cheboygan
Lockwood MacDonald Hosp	John L Shields, MD	Wendell Trent	Douglas Hames (WSU)	East Lansing, Ingham
PLAINWELL, Pipp Comm Hosp	Van D Keeler MD	Arthur G Wolfe	Judith C Holt (U-M)	Kalamazoo, Kalamazoo
PONTIAC General Hosp	Robert T Lyons, MD	Roger B Nelson, MD	Stephen Shogan (U-M)	Bloomfield Hills
			George Gaudzels (U-M)	Grand Rapids, Kent
			Steve Grant (U-M)	Bloomfield Hills
			Rick Olson (WSU)	Mason, Ingham
			Katherine Andary (U-M)	Dearborn, Wayne
			Michael I. Wertz (WSU)	Huntington Woods
			Kenneth McMillan (WSU)	Pontiac, Oakland
			Jeffrey Dembs (WSU)	Southfield, Oakland
			Gregory Schimizzi (WSU)	Dearborn, Wayne
			Robert Moss (MSU)	Southfield, Oakland
PORT HURON Hospital	Anthony Gholz, MD	Charles McKinley	Linda Gerritts (U-M)	St Clair, St. Clair
			Ralph Zade Jr (WSU)	Detroit, Wayne
ST CLAIR, River District Hosp	Harry Mayhew, MD Segundo Danao, MD	E.V Slingerland	Joel Bremer Jr. (WSU)	St. Clair, St Clair
			David Powles (WSU)	Detroit, Wayne
ST JOHNS, Clinton Mem Hosp	James Grost, MD	Paul McNamara	Charles Pollard (U-M)	Mt. Pleasant, Isabella
ST JOSEPH, Mem Hosp	Robert L Green, MD	R A Bradburn	Manuel Mesirow (U-M)	Benton Harbor, Berrien
			Lawrence Newman (U-M)	Skokie, Ill.
			Barry Nemon (WSU)	Southfield, Oakland
SALINE, Community	Gerald Stair, MD	Vincent Catacuzzeno	Gregg Warshaw (U-M)	Ann Arbor, Washtenaw
SAULT STE. MARIE, Chippewa Co War Mem. Hosp	Donald Finlayson, MD	William McMillan	Bruce Reinoehl (MSU)	East Lansing, Ingham
			Bruce Purvis (U-M)	Birmingham, Oakland
SOUTH HAVEN, Comm. Hosp	Joseph Cooper, MD	Robert Traxler	Michael Ledtke (MSU)	Saginaw, Saginaw
			James Shiovitz (WSU)	Detroit, Wayne
STURGIS, Mem Hosp.	Robert Lewis, MD	Stan Fleece	Barry Allswang (WSU)	Chicago
			John Moss (WSU)	Sturgis, St. Joseph
VICKSBURG, Franklin Comm. Hosp	Lloyd Appell, MD	Mrs Robina Bowers	David Nadelman (U-M)	Kalamazoo, Kalamazoo
WEST BRANCH, Tolfree Mem Hosp	Howard Van Oosten, MD	Larry Sieffert	Jeffery Gay (U-M)	Alma, Gratiot

Taking the blood pressure of Michigan Rep. William R. Copeland, Wyandotte, left, is Mrs. Margaret Zirbes, in charge of the legislature's first aid station. Walter D. Meester, MD, Grand Rapids, MSMS Physician-of-the-week, stops by to offer any necessary assistance.

Mrs. Zirbes, RN, cares for legislators with MSMS aid

"I have a miserable cold."

"Mrs. Zirbes, do you have an aspirin. Make it two."

The lawmakers' requests for aid come thick and fast as the Michigan legislature convenes on a typical afternoon. And Margaret Zirbes, RN, does have the medicines the ailing legislators need, thanks to MSMS. The state society supplies medications and equipment for first aid and emergency care of senators, representatives, clerks, pages and all Capitol employees from the governor on down.

"I take care of the whole Capitol," says Mrs. Zirbes with a wave of her hand. Her second floor post is just off the rotunda balcony and down the hall from the Senate and House chambers.

Since first manning the Capitol First Aid Station in 1968, Mrs. Zirbes has specialized in preventive medicine, even preparing gallons of lemonade and iced tea for long, hot summer sessions.

Mrs. Zirbes has a background of over 30 years in public health nursing and has been honored by the Capitol employees, the East Lansing Lions Club and the legislators, who passed a concurrent resolution in 1970. The resolution added to her degrees a TLC, for Tender Loving Care, and honored her for her kindness, helpfulness and graciousness.

MAFP scientific meet July 16 - 18 schedules special events

A number of special events will add gliter to the 27th annual Scientific Assemble of the Michigan Academy of Family Physicians, planned July 16-18 at the Park Place Motor Inn, Traverse City.

James L. Grobe, MD, of Phoenix, Ariz., president of the American Academy of Family Physicians, will be on hand Monday evening, July 16, to install the new officers, headed by Louis R. Zako, MD, Birmingham, incoming president.

In addition, a "Family Physician of the Year" will be named. The distinguished faculty for the scientific meetings will include out-of-state speaker James W. Wilson, MD, PhD, Department of Pathology, Duke University, who will discuss shock.

Other special events will include a golf tournament, fishing derby and scenic tour for physicians' spouses that will take in Interlochen National Arts Camp and Academy, Sleeping Bear Dunes, Frankfort, Crystal Lake and Leland. In addition, the Cherry County Playhouse, adjacent to the Park Place Motor Inn will feature Soupy Sales in "Come Live with Me," on Sunday evening, July 15, and Tom Boseley in "A Shot in the Dark," on Tuesday, July 17.

TB Association honors MSMS

A citation has been received by MSMS from the Michigan Tuberculosis and Respiratory Disease Association "for outstanding service toward improving community health in the fight against emphysema, tuberculosis and air pollution." MSMS efforts in these fields are carried out by the MSMS Committee on Public and Environmental Health and the MSMS Committee on Public Relations.

Zip code 48823

Letters to the editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to editing. Address all correspondence to: The Editor, Michigan Medicine, 120 W. Saginaw St., East Lansing, 48823.

Doctor Broadman has unique method to determine reasonable fee

To the editor:

We of the medical profession, except in isolated instances being notoriously poor business men, have gradually allowed third parties to encroach further and further into the business aspects of our profession, to the point where unless we rear up in opposition, short of unionization, we are going to lose completely our right to have a voice in the determination of the value of our services.

We have degraded ourselves, and prostituted our profession, by accepting without introspection or critical analysis, the artificial criteria laid down by insurance companies, whereby we must accept payment on a non-professional "time and material" concept, without any consideration for professional factors requiring personal and professional judgment, which would be to our advantage to be considered, but of which, these third parties have denied the existence. How does one charge for diagnostic acumen, exploitation of experience, application of knowledge, worry and sleeplessness over patients, prevention of complications by good clinical judgment opposed to fallacious laboratory results, comforting distraught relatives, evasion of complications with good medical practice? Just how? Insurance companies refuse to acknowledge the existence of these factors in the determination of "reasonable" fee payments and base the rest of it soley on time spent actually attending the patient, with numerous evasions such as "prolonged attention" rather than "professional skill and responsibilities" etc. They, from the questions they pose, feel that a complication, even of a preventable type, justifies a higher fee because it takes longer to cure, rather than a well handled case in which complications are prevented, and approximately a hundred dollars per day for hospital charges are saved them, through the use of good medical procedures!

Isn't there another way to determine a reasonable fee? There certainly is.

The insurance companies expound that of the three groups involved; i.e. patient, doctor and insurance company, the only one competent to determine what constitutes a reasonable fee is the insurance company. However, if the patient and the doctor agree on the fee then it must be considered reasonable. Once the reasonableness of it is established, if other criteria such as "customary and usual" do not fit the fee, it is the criteria, not the fee that are at fault.

There is, however, an even better procedure to determine a reasonable fee. If the patient and the doctor can arrive at the figure independently of each other, which is agreeable to both, then who can logically question as to whether the fee is reasonable? This is especially true *if the patient independently establishes the fee* and the doctor concurs, not vice versa.

In one office in the case of special, complicated, severe, or unusual disease processes, i.e. any hospitalized case of more than usual and customary complexity, or requiring more than the usual and customary medical parameters, without informing the patient as to the amount, the doctor places his estimate of a reasonable fee on a slip of paper and into his pocket. He then states to the patient; "if you had no insurance, what would you consider a reasonable fee for my service under the circumstances?" After the patient has expressed himself, he is then shown the doctor's estimate. The doctor then has the choice of either accepting the insurance company's payment schedule, or billing the patient for the larger of the two estimates with a reduction to the small amount if the bill is paid within a reasonable time, say ninety days and both the patient and the insurance company are apprised of this arrangement. The patient is also informed that "in accordance with the policy established by a large insurance company in the state, should his insurance company fail to cooperate and he desires to take legal action, the doctor would cooperate with him."

From then on, it is quite amusing to sit back and watch the insurance attempt to evade its responsibility!

This method completely removes the doctor from the habitually defensive position of justifying his fee, and places the defense elsewhere where it belongs!

Yours truly,
Sylvan Broadman, M.D.

Doctor Jesson believes Blue Shield must move to reconcile

To the Editor:

I wish to take exception to the comments of Dr. Robert M. Leitch, Chairman of the Council, which appeared in the May issue of *Michigan Medicine.*

It does not seem possible to me that Dr. Leitch has forgotten what transpired in the House of

Delegates and throughout the state from 1969 until 1972. Apparently these unpleasant matters must come up again since the thrust of his message is to resume a marriage that was dissolved after much discussion by action of the majority of MSMS representatives.

Dr. Leitch's brief summary on the history of the relationship between MSMS and Blue Shield is factual. I do not know what other factors mentioned in the necessity for the divorce were, but could some of them have emanated from the administration of Blue Shield? Has Dr. Leitch forgotten the letters sent to subscribers which MSMS protested so bitterly? Has he not had in his community the selling tactics of the agents of Michigan Medical Service telling the consumer when he purchased the policy that it paid everything and that there should be no additional charges, and, if so, the doctor was not honest in his dealings with the subscriber? Perhaps Dr. Leitch has forgotten the failure of Blue Shield to cooperate in any way with changing the DSR or to discuss the use of MSMS procedure codes. Has he tried to change his payment profile?

I only mention the above because I don't believe that a marriage can be reconciled unless there is an active effort on the part of both for reconciliation. Any efforts of MMS have been well concealed. From my recollection of events as only a very interested observer, it seemed to me that MSMS made many efforts to cooperate and work with the administration of Blue Shield in the past, but since these efforts were continually rebuffed or ignored, it finally became the policy of MSMS to dissolve itself as a corporate body of this organization. I hold that now it is time for Blue Shield to make some efforts to repair the breach. Until some changes in the things that were wrong before come about, why waste the time of the Council or a committee?

The thrust of my message, Dr. Leitch, is that MSMS may need Blue Shield and vice versa, but it is a two way street. The spectre of NHI does not change this.

By the time this letter is printed (if it is) the spring house of delegates will have met. In my opinion, our organization has made a decision about our relationship with Blue Shield and further discussion is unnecessary on a matter which can only serve to divide MSMS unity.

Very sincerely yours,

Robert M. Jesson, M.D.

Michigan OB-GYN Society liked subcommittee report in *Michigan Medicine*

Michigan Society of Obstetricians and
Gynecologists
1105 Kales Building
Detroit, Michigan 48226

May 20, 1973

Richard T. Mellis, M.D., Chairman,
Maternal and Perinatal Health
Committee of MSMS.

Dear Dr. Mellis:

At its last meeting, the Council of MSOG took note of the exceptional work of your subcommittee as reported in the March '73 issue of *Michigan Medicine*. The Council supports and strongly endorses the recommendations of your subcommittee. Further, we would like to extend our compliments to Dr. Harrison Visscher and the hard working members of his subcommittee for a difficult job well done, and unselfishly done, in the best interests of the Obstetrical Patient, and in line with the high standards of our specialty.

Best regards,

Robert G. Walkowiak, M.D.
Secretary

Doctor Frazier asks about renowned physicians, insect bites

To The Editor:

I am editing a book on renowned and notable physicians and their faith.

I am interested in obtaining contributors who have a special knowledge of the faith and/or religion of one or more notable and outstanding physicians. I am considering such physicians as Sir William Osler, and Sir William Fleming, however the notable physicians could still be alive.

Also, this year I am again compiling case reports of allergic reactions to biting insects, i.e., mosquitos, fleas, gnats, kissing bugs, bedbugs, chiggers, black flies, horseflies, sandflies, deerflies, etc. I am also interested in reactions to the Imported and Southern Fire Ants.

I would like physicians to supply me with case reports of those patients who have had reactions to such insects. Include in your reports the type of reaction and the complications, if any, the age, sex, and race of the patient, the site of the bites, the season of the year, the immediate symptoms, the skin test results, desensitization results, if any, and any associated other allergies. Send this information to the following address:

Claude A. Frazier, M.D.
4-C Doctor's Park
Asheville, NC 28801.

Small doses

Donald G. Albert, MD, Royal Oak,
is new president-elect of the Michigan Heart Association. He will take over in May, 1974, succeeding Raymond Fuller, MD, Grand Rapids, who was recently installed as president of the heart association.

Samuel J. Behrman, MD, Ann Arbor
will present the first S. Leon Israel Memorial Lecture June 21 at Pennsylvania Hospital in Philadelphia. Doctor Behrman is director of the U-M Center for Research and Training in Reproductive Biology and professor of ob-gyn.

Leonard F. Bender, MD, Ann Arbor,
is president-elect of the American Academy of Physical Medicine and Rehabilitation and will assume his presidential duties in late summer. Doctor Bender is a professor in the Department of Physical Medicine at the U-M Medical School.

H. Curtis Benson, MD, Kalamazoo,
is new MSMS representative to the Governor's Steering Committee to Develop a State Plan for the Prevention, Detection and Treatment of Kidney Disease. Doctor Benson is director of the Hemodialysis Unit at Bronson Hospital.

Duane L. Block, MD, Lathrup Village,
is a new member of the Detroit Hearing and Speech Center board of directors. The medical director of the Ford Motor Co., Doctor Block will serve a three-year term on the center's board.

Melvin A. Block, MD, Detroit
is one of six U.S. physicians selected to comment on treatment of hyperthyroidism by thyroidectomy in the May 28 issue of *Modern Medicine.* Doctor Block is associate surgeon at Henry Ford Hospital.

Michigan Week honors go to two physicians

Two Michigan physicians received top state awards during Michigan Week ceremonies May 22.

They were Walter H. Seegers, MD, Grosse Pointe Farms, WSU School of Medicine professor, recipient of one of 25 Governor's Minuteman Awards for bringing world-wide medical prominence to Michigan for his work in blood research; and C. Mark Vasu, MD, Grand Rapids, who was awarded one of 10 Volunteer Leadership citations for his outstanding efforts to establish good emergency medical care in Kent County.

The awards were made by Mrs. William G. Milliken in Lansing.

Don W. McLean, MD, center, chairman of the Wayne County Medical Society Library Committee, congratulates William J. Stapleton, Jr., MD, at left, as WSU President George E. Gullen, Jr., looks on at the unveiling of the Stapleton bas relief. The unveiling took place recently at the WSU School of Medicine Library with more than 150 friends of Doctor Stapleton in atendance. The copper relief, two feet in diameter, is located in the Stapleton Reading Room of the Shiffman Medical Library. Dr. Stapleton, 96, the MSMS historian, is the second oldest living graduate of the School of Medicine.

Alice F. Campbell, MD, Albion,
is a recipient of one of five 1973 Distinguished Alumni Awards from Albion College. Doctor Campbell, now retired and living in Laguna Beach, Calif., was a family physician and anesthetist in Albion for 36 years. She had served residencies in obstetrics and pediatrics and is a graduate of the University of Michigan Medical School. She also was a civic leader.

Jerome W. Conn, MD, Ann Arbor,
is currently visiting professor of endocrinology at four medical schools in Spain. Previous to that, he recently completed an assignment as the first annual Morsman Visiting Professor in Endocrinology at the University of Nebraska Medical Center. He has received the U-M's two highest faculty honors and is currently the Newburgh University Professor of Internal Medicine.

C. Jackson France, MD, Detroit,
was one of five distinguished alumni of Wayne State University to be honored June 16 at the 105th annual WSU Alumni Reunion. Doctor France is clinical associate professor of surgery at WSU School of Medicine, has a private practice

(Continued on page 486)

Clinton hospital chief of staff new board member

The trustees of the Clinton Memorial Hospital in St. Johns have set a precedent in their organization by naming a physician to the hospital's board of directors.

And they have taken the unique step of naming the hospital's chief of staff, James M. Grost, MD, ensuring that their new eighth board member will be an active physician with direct involvement in the hospital's daily efforts. They also have ensured the contribution of a rotating group of physicians to the board, as chiefs of staff change over the years.

"The chief of staff always has been present at board meetings in the past. And his opinions always have been well received," says Doctor Grost. Now, however, he also has a vote and committee privileges.

Physician membership on hospital boards has been strongly recommended by the Joint Commission on Accreditation of Hospitals and encouraged by MSMS in Michigan.

"Increasingly, hospitals are going to this," says Doctor Grost. But he believes his Clinton County Hospital situation is better than that of the hospitals who place physicians on their larger boards of trustees, often choosing inactive MDs, and placing them in lifetime positions.

SMALL DOSES/Continued

in Harper Woods and is a former chief of staff at St. John Hospital.

Delano G. Meriwether, MD, Boston,
who completed his undergraduate education at Michigan State University and has won national and international championships in track and field competition, is a new White House Fellow, to serve in 1973-74 with the federal government in Washington. Doctor Meriwether is a fellow in hematology at Harvard Medical Unit, Thorndike Memorial Laboratory, Boston City Hospital.

Glenn E. Moore, MD, Flint,
has been re-elected to serve as moderator of the Council of Specialty Societies for 1973. New vice moderator is Arthur J. Johnson, MD, Detroit. Doctor Moore is a general surgeon, while Doctor Johnson is a urologist.

James W. Rae, MD, Ann Arbor,
currently is serving as president of the American Congress of Rehabilitation Medicine. He is chairman and professor of physical medicine at the U-M Medical School.

Fred C. Sabin, MD, Marquette,
is new president of the Association of Mayo Eyefellows, former fellows in ophthalmology at the Mayo Clinic, Rochester, Minn. Doctor Savin also is chairman of the board of control of Northern Michigan University and a past member of the State Board of Registration in Medicine.

Edwin Smith, MD, Ann Arbor,
is president of the Michigan Academy of Physical Medicine and Rehabilitation. He was installed in November and is a professor in the Department of Physical Medicine at the U-M Medical School.

Josh S. Williams, MD, Detroit,
is the Physician of the Year of the Detroit Medical Society. Doctor Williams is past president of the DMS and currently speaker of the National Medical Association House of Delegates. He is a family physician and active in medical and community organizations. He is a member of the board of the Michigan Doctors Political Action Committee and of the MSMS Committee on Hospital Privileges.

Henry J. Winkler, MD, L'Anse,
is the subject of a long and warm feature in the Marquette *Mining Journal* recognizing him for his 48 years of service as physician to his community. Doctor Winkler, 79, still makes rounds at Baraga County Memorial Hospital, which he staffed singlehandedly in its early days, and at the Winkler Extended Care Facility, which he built in 1963.

Detroit "movers" include two MDs

The *Detroit News* recently carried a feature about "Detroit Movers" and included two doctors among the people "involved in getting Detroit out of its doldrums."

Among the "movers" identified were Charles Wright, MD, who received an MSMS Certificate of Commendation several years ago for his leadership in medical and community affairs; and Charles Whitten, MD.

Doctor Wright was cited for his efforts to develop an Afro-American museum; and Doctor Whitten was praised for his efforts as president of the Sickle Cell Detection and Information Program in Detroit.

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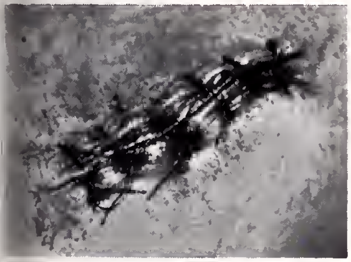

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Pro-Banthīne is provided in several different dosage forms and combinations which will meet virtually any clinical need. It is just as versatile in filling patient needs, among which are:

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"Sustained" action—Pro-Banthīne P.A.® (propantheline bromide) contains 30 mg. of the drug in the form of sustained-release or timed-release beads; on ingestion about half of the drug is released within an hour and the remainder continuously as earlier increments are metabolized.

High-level anticholinergic activity is maintained all day and all night in most patients with only two tablets every eight hours.

"Analgesic" action—Pro-Banthīne helps to control the acid-spasm-pain complex.

A "diagnostic tool"—Pro-Banthīne may be used parenterally to immobilize the duodenum for more revealing roentgenographic appraisal through hypotonic duodenography.

Pro-Banthīne is considered adjunctive in total peptic ulcer therapy that may include diet, conventional antacids, bed rest, and other supportive measures.

Vigorous anticholinergic action — Pro-Banthīne® Vials, 30 mg., are for intramuscular or intravenous use when prompt and vigorous anticholinergic action is required.

Mild anticholinergic action—Pro-Banthīne® Half Strength, 7.5-mg. tablets, for more exact adjustment of maintenance dosage in mild to moderate gastrointestinal disorders.

Indications: Pro-Banthīne is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution.

Fever and possibly heat stroke may occur due to anhidrosis.

In theory a curare-like action may occur, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthīne.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

Pro-Banthīne P.A.—Each tablet of Pro-Banthīne P.A. (propantheline bromide) contains 30 mg. of the drug in the form of sustained-release or timed-release beads; on ingestion about half of the drug is released within an hour and the remainder continuously as earlier increments are metabolized. Thus the result is even, high-level anticholinergic activity maintained all day and all night in most patients with only two tablets daily. Some patients may require one tablet every eight hours.

The contraindications and precautions applicable to Pro-Banthīne 15 mg. should be observed.

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SPARES POTASSIUM IN BOTH

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

*Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (> 5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules.

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A keynote speaker for the Rural Health Conference was Donald C. Smith, MD, Ann Arbor, director of the Governor's Office of Health and Medical Affairs. His topic was "Dimensions of a needed health care policy for rural communities."

The new and developing family medicine programs and their importance to health care in rural communities were discussed by this panel, from left, Robert L. Vitu, MD, Saginaw, president, Michigan Academy of Family Physicians; Robert C. Ward, DO, chairman, Department of Family Medicine, MSU College of Osteopathic Medicine; moderator Sidney Katz, MD, director, MSU Office of Health Services Education and Research, and Donald Weston, MD, Associate Dean, MSU College of Human Medicine.

Scenes of 1973
Michigan Conference on Rural Health

The Michigan Health Council, cosponsor with MSMS and Michigan State University of the Rural Health Conference, presented a Distinguished Service Award during luncheon ceremonies to J. Kenneth Altland, MD, left, Lansing, for his service as a family physician and later public health administrator, as well as his nearly 25 years as officer and trustee of the MHC.

Otto K. Engelke, MD, left, was among three health professionals newly elected to the Health Council's Health Hall of Fame. Doctor Engelke was recognized for his state and national leadership in medical and public health fields. Presentations were by John C. McCabe, president, Michigan Blue Shield, host for the luncheon.

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Most people can handle this tension.

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.

Valium®
(diazepam)

To help you manage excessive psychic tension

Ancillary

Michigan's residencies in family practice are producing

By Judith Marr
Managing Editor

Michigan's six new programs to train residents in the family practice specialty are producing several badly-needed new family physicians this spring.

"One of our main goals is to attract the graduates to practice in Michigan," explains Robert L. Vitu, MD, Saginaw, president, Michigan Academy of Family Physicians. The Academy is very much interested in the family practice residencies, he explains, is actively promoting the residency programs and aids new programs in getting started.

"We feel the new programs here are highly successful," he continues. "It is my general impression that at least half of their graduates are locating in Michigan. And most of the programs more than a year old are beginning to fill their quotas completely.

"During the past year it's become more clear to me that the only way to solve Michigan's physician shortage—and especially in the rural areas—is to produce more family physcians," continued Doctor Vitu.

"I think we're moving in the right direction," he says. "The numbers of graduates are small now but maybe in another six years they will be making a big dent in the shortage."

A total of ten new family physicians are completing their three year residency at family practice centers in Midland, Saginaw, Lansing, Flint and Dearborn this year. Eight of them will stay in Michigan to practice. Grand Rapids' program, just underway, has no graduates, of course.

Midland has had three total graduates previous to this year, all of which have remained in Michigan to practice. The program, founded in 1969, has one graduate this year. He will go to Kansas to practice. Eighteen residents will study in the program next year. Charles P. Schoff, MD, is director.

At Saginaw, where the program was founded in 1967 and accredited in 1969, there have been six previous graduates, with three of them remaining in Michigan. One graduating this June will enter the U.S. Navy, and one who will graduate in December will remain in Saginaw. Thirteen residents will be working in the program during the 1973-74 year. Roy J. Gerard, MD, is director.

Lansing, accredited three years ago, has its first two graduates this June. One will practice in Jackson and the other in Grand Ledge. The Lansing program will have 15 residents next year. Harold E. Crow, MD, is director.

Flint and Dearborn programs also have their first graduates this year, and were accredited just three years ago.

At Flint, the one graduate will remain in Flint to practice, while six residents will be enrolled in the program next year. The director there is Louis E. Simoni, MD.

Dearborn's program, directed by Everall M. Wakeman, MD, has three graduates, all of them remaining in Michigan to practice. Ten residents will continue in the program in 1973-74.

Grand Rapids' fledgling program, which gets underway in July, will have six residents enrolled and is under the direction of John P. Newton, MD.

As an interesting sidelight, Michigan has done very well in accumulating new family physicians. Of the total of 18 new family physicians graduated to date from the residency programs, 13 have remained to practice in Michgian. Only five of these were originally from Michigan.

SOME PHYSICIANS KNOW what to do with their patients who are alcoholics or problem drinkers.

SOME PHYSICIANS WISH they knew what to do with them.

Have you thought of the Alcoholism Services of the Battle Creek Sanitarium Hospital? Since 1965 we have maintained an enviable record in the rehabilitation of the alcoholic or problem drinker.

A full range of services and specialties.

Give us a call
616-964-7121 Ext. 588 or 589

Battle Creek Sanitarium Hospital
197 N. Washington Avenue
Battle Creek, Michigan 49016

Michigan med students honor outstanding instructors

Students at Michigan's three medicals schools honored their outstanding instructors as they ended their academic year this spring.

At Wayne State University, the graduating senior class chose Charles C. Vincent, MD, assistant professor of obstetrics-gynecology, as their marshal for commencement exercises, a traditional honor for an outstanding teacher.

The WSU students also singled out Vainutis K. Vaitkevicius, MD, professor of internal medicine and chairman of oncology, for "lampooning" honors, humorous recognition of a favorite instructor.

At June 8 graduation exercises at the University of Michigan, the senior medical class selected as best clinician Richard Dow, MD, assistant professor of surgery; and presented the Elizabeth Crosby Award for the outstanding faculty member in basic sciences to Sarah Winans, PhD, assistant professor of anatomy and director of neural and behavioral sciences.

Five practicing physicians who train students from Michigan State University's College of Human Medicine in community hospitals in Flint, Grand Rapids, Jackson, Saginaw and Lansing were honored by the MSU students for their outstanding teaching and devoted service.

Certificates of Merit were awarded at the June commencement convocation to Bert M. Bullington, MD, Saginaw, internist; E. Marshall Goldberg, MD, Flint, internist; Mark E. Heerdt, MD, Lansing, anesthesiologist; Robert E. Medlar, MD, Jackson, surgeon, and Ralph W. Ortwig, MD, Grand Rapids, surgeon.

On-campus teaching excellence was recognized with the presentation of the MSU Distinguished Teacher Award to Joan C. Mattson, MD, associate professor on the fulltime pathology faculty.

MSU graduates first new DOs

The nation's first DOs to graduate from a university-based osteophatic medical college received their degrees June 10 from Michigan State University. The 42 new physicians include 28 who will be interning in Michigan hospitals. The MSU Osteopathic College was founded in 1970.

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Hypocrisy, double standards must be ended before physicians can participate with Blue Shield

The four physician-members of the Michigan Blue Shield Board of Directors were asked to contribute an article for ***Michigan Medicine*** *on the major problems, as they see them, facing MBS today. Here is one offering:*

By Charles Rogers, MD, FACS
Bay City

Blue Shield, sired by proud physicians, and once a beautiful baby, has now grown up to be our mother-in-law. We must live with her and she needs us to exist. We both stand assai deep in a socio-economic swamp, surrounded by politically inspired, socialist alligators who may devour us for lack of meaningful communication and common objectives.

It is difficult under such circumstances for Blue Shield and us to remember that our primary objective is to provide health care, at reasonable cost, for all who need it, including the alligators.

Pre-payment schemes devour, in operating expenses, some 10 to 50 percent of the consumer's dollar before any payment is made to those who provide the care. It would be more logical for the patient to pay the provider directly a dollar for a dollar's worth of care before the 10 to 50 percents have their hand in the till. Nonetheless, it is too late to debate the issue

The public has been sold on the concept of prepaid medical care. We helped impregnate the idea. It is too late for an abortion.

We must concern ourselves with preserving the best pre-payment plans. Medical foundations, metropolitan-Dow, or HMOs, may be better plans, but they must stand the tests of time, competition and adversity.

The Metro plan and other per capitation concepts may be cheaper, but so are Yankee stores. They risk assembly-line type care, underutilization and mediocrity. Should the consumer opt this route, then cry lack of quality or individual consideration, allow me at least the freedom of turning down my hearing-aid.

Blue Shield must oppose those who measure success in terms of votes, including labor union officers. She must convince representatives of consumers of the difference between wants and needs. The consumer cannot afford all he wants in health care anymore than he can afford all he wants in housing.

We must educate the consumer in the concept that socialized doctors have socialized patients. In countries where medical practice has been nationalized, this has not only failed to solve health care problems, but has been the first step in socializing the political and economic system of the country. We and Blue Shield must not, like impotent Indians, allow the government to assign us to a socialistic reservation.

The government's role in farming, the postal system, and housing does not recommend it as the successor to Blue Shield. A veteran's hospital is a nice place to be, particularly in a snow storm, during a flood, but it is probably the world's most expensive medical program. Although politically unwise, Blue Shield must summon courage to propose limits and oppose union spokesmen who advocate Teddycare.

Blue Shield must conceive ways to work with providers. She must rid herself of hypocrisy. She advocates professional standards while practicing the lesser standards of the market place. Blue Shield, the Motors Plan, must become the Concerned Citizen's Plan.

Start by revising the most one-sided contract since slavery, the providers participation agreement. Eliminate double standards such as: advocating informed consent, including cost, while deceiving the subscriber regarding coverage and payments; varying fees by geography without equivalent variants in premiums; parroting politicians while posing as an ally; supporting fee freezes while incurring 15 - 20% annual increases in operating expenses, and most importantly, a willingness to sell the public anything it wants while insisting that the physician provide only that which is needed, and prove it.

The hypocrisy and double standards must be eliminated before physicians can "participate" with their mother-in-law, Blue Shield, in mutually advantageous endeavors to rid the socio-economic swamp of politically inspired alligators.

ABBOTT

Placidyl®
(ETHCHLORVYNOL)
Brief Summary

Indications—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

Contraindications—Drug hypersensitivity and porphyria.

Warnings—Not recommended during the first and second trimester of pregnancy. Caution patients of possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

Precautions—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitryptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

Adverse Reactions—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 307454

Give us her nights.

Prescribe Placidyl. Chances are, we'll give her a good night's sleep.

There are nights . . . particularly as that certain day draws near . . . when discomfort or apprehension make sleep difficult. And she needs sleep.

When sleep is synonymous with therapy, remember . . . Placidyl is synonymous with sleep. It has been for over 17 years.

If time is the criterion to inspire your confidence . . . you can rest assured with Placidyl.

Not recommended during the first and second trimesters of pregnancy.

Prescribed by physicians for over 17 years.

Placidyl® Ⓒ IV

(ETHCHLORVYNOL CAPSULES, 500 or 750 mg.)

Doctor Penner heads WSU Med. School alumni

New officers recently were selected to lead the Wayne State University School of Medicine Alumni Association.

They are David A. Penner, MD, West Bloomfield, president; James J. Horvath, MD, Grosse Pointe, honorary president; Joseph R. Montante, MD, Orchard Lake, president-elect; James J. Aiuto, MD, Detroit, treasurer, and Robert S. Levine, MD, Birmingham, secretary.

New board members include Nanette Jagnow, MD, Birmingham, filling the unexpired term vacated by new president Doctor Penner; Louisa I. Piccone, MD, Detroit, Andrew E. Stefani, MD, Grosse Pointe, and Allan D. Stilwell, MD, Pontiac, all serving terms ending in 1976.

David A. Penner, MD, left, accepts the gavel from James J. Horvath, MD, and becomes 105th president of the WSU School of Medicine Alumni Association, at ceremonies on May 8.

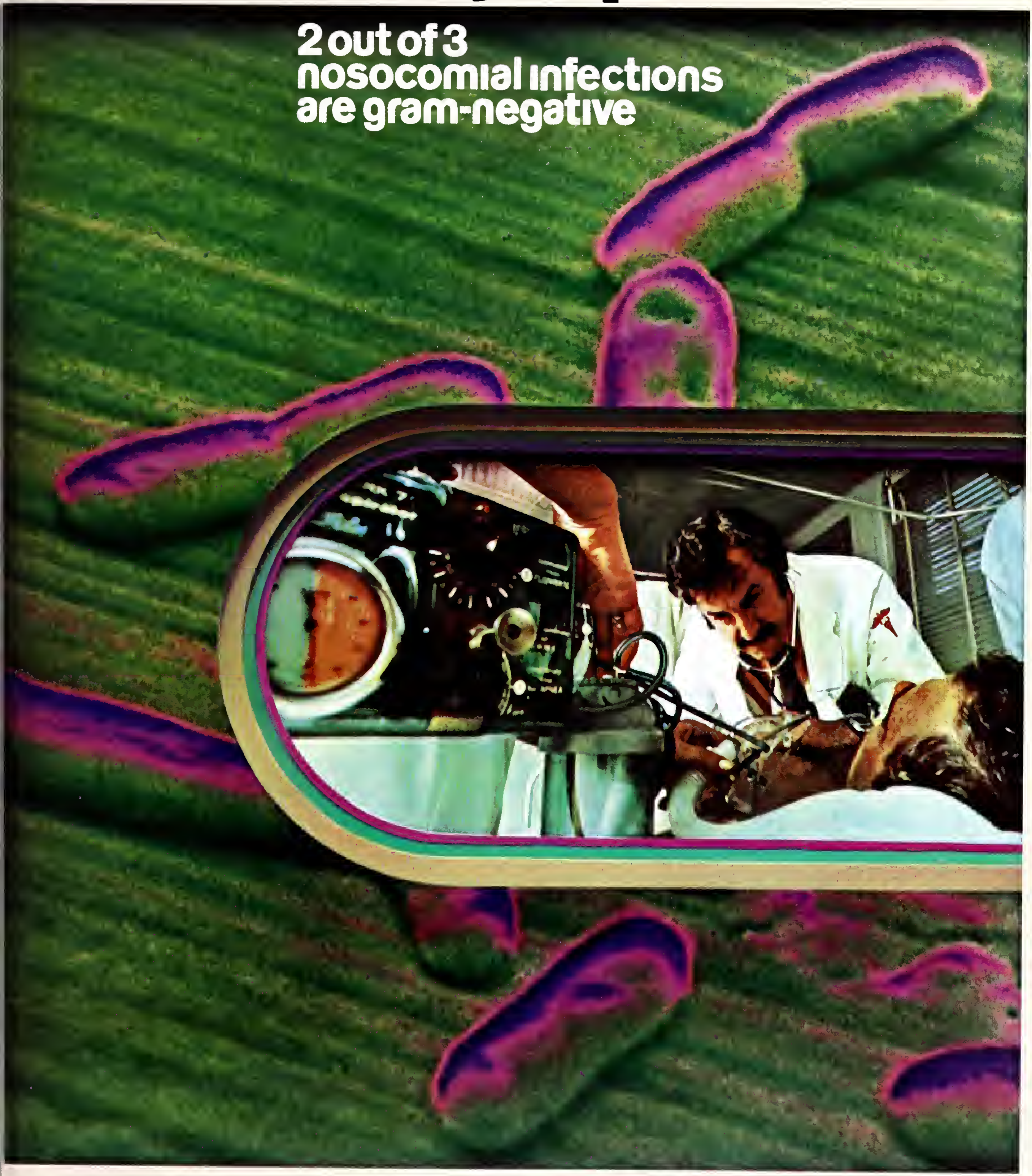
David A. Penner, MD, right, presents a Distinguished Alumni Service citation from the WSU School of Medicine Alumni Association to Robert M. Nalbandian, MD, 1954 WSU graduate, WSU adjunct associate professor of physiology, and also associate pathologist at Blodgett Memorial Hospital, Grand Rapids. Doctor Nalbandian was honored for his contributions to the detection and treatment of sickle cell disease and for his work in the concept of molecular medicine.

Joseph J. Montante, MD, left, presents a Distinguished Alumni Service citation from the WSU School of Medicine Alumni Association to Paul H. Muske, MD, 1935 WSU graduate and attending physician in obstetrics and gynecology at Providence Hospital, Southfield. Doctor Muske was honored as an outstanding example of those practitioners dedicated to their large practices and to community and family involvement.

Wardell B. Pomeroy, PhD. left, explains a point to James J. Horvath, MD, center, and Mario A. Petrini, MD, moderators of Wayne State University School of Medicine Alumni Association's 1973 Clinic Day program on Human Sexuality. Doctor Pomeroy, New York City marriage counselor and psychotherapist and associate of the late Doctor Alfred Kinsey, discussed "Communicating With Patients About Sex" as principal speaker.

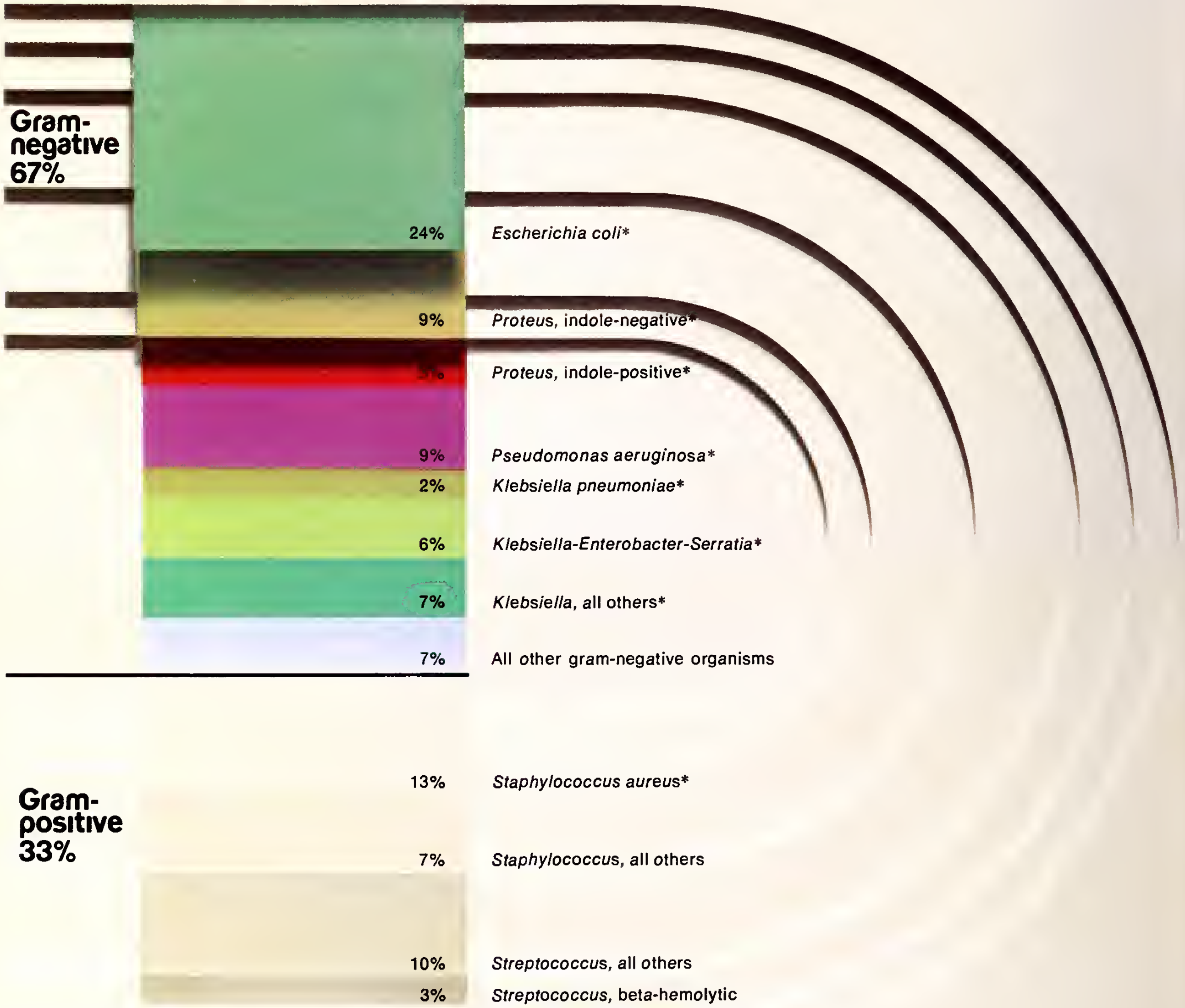
Schering

On all in-patient services...
a major problem


2 out of 3
nosocomial infections
are gram-negative

Gram-negative bacteria magnified 10,000 times—color-tinted

Commonly encountered pathogens on all hospital services



Gram-negative 67%

% Incidence	Pathogen
24%	*Escherichia coli**
9%	*Proteus*, indole-negative*
3%	*Proteus*, indole-positive*
9%	*Pseudomonas aeruginosa**
2%	*Klebsiella pneumoniae**
6%	*Klebsiella-Enterobacter-Serratia**
7%	*Klebsiella*, all others*
7%	All other gram-negative organisms

Gram-positive 33%

% Incidence	Pathogen
13%	*Staphylococcus aureus**
7%	*Staphylococcus*, all others
10%	*Streptococcus*, all others
3%	*Streptococcus*, beta-hemolytic
0%	All other gram-positive organisms

Total pathogens 21,972
Source: Gosselin Audit of Pathology Cultures—1971

*GARAMYCIN Injectable is effective against susceptible strains of the pathogens indicated.

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Schering

A highly appropriate spectrum for today's problem pathogens

GARAMYCIN Injectable offers a high probability of effectiveness against susceptible strains of seven out of seven major gram-negative pathogens. These are:

Escherichia coli
Proteus, indole-negative
Proteus, indole-positive
Pseudomonas aeruginosa
Klebsiella }
Enterobacter } species
Serratia }

GARAMYCIN Injectable has also been shown to be effective in serious staphylococcal infections. It may be considered in those infections when penicillins or other less potentially toxic drugs are contraindicated and bacterial susceptibility testing and clinical judgment indicate its use.

Start with Garamycin

■ **Broad gram-negative spectrum**
Because of its broad gram-negative spectrum and its well-established clinical efficacy, GARAMYCIN Injectable can be considered for initial therapy in suspected as well as documented gram-negative sepsis.

Stay with Garamycin

■ **Susceptibility of causative organisms confirmed**
The results of susceptibility tests will, in most cases, demonstrate the causative organisms' sensitivity to GARAMYCIN Injectable. However, the decision to continue therapy with this drug should also be based on the severity of the infection and the important additional concepts contained in the Warning Box.

■ **Relatively low incidence of adverse reactions**
Risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.

■ **Bacterial resistance has not been a problem**
In the laboratory, resistance has been demonstrated to develop slowly in stepwise fashion. No one-step mutations to high resistance have been reported to date.

In serious gram-negative infections (pneumonia, urinary tract infections, septicemia, and wound infections)*
*Due to susceptible organisms

On all in-patient services...

Garamycin®

gentamicin sulfate
injectable
I.M./I.V.

40 mg. per cc.
Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin

WARNING
Patients treated with GARAMYCIN Injectable should be under close clinical observation because of the potential toxicity associated with the use of this drug.

Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment.

Monitoring of renal and eighth nerve function is recommended during therapy of patients with known impairment of renal function. This testing is also recommended in patients with normal renal function at onset of therapy who develop evidence of nitrogen retention (increasing BUN, NPN, creatinine or oliguria). Evidence of ototoxicity requires dosage adjustments or discontinuance of the drug.

In event of overdose or toxic reactions, peritoneal dialysis or hemodialysis will aid in removal of gentamicin from the blood.

Serum concentrations should be monitored when feasible and prolonged concentrations above 12 mcg./ml. should be avoided.

Concurrent use of other neurotoxic and/or nephrotoxic drugs, particularly streptomycin, neomycin, kanamycin, cephaloridine, viomycin, polymyxin B, and polymyxin E (colistin), should be avoided.

The concurrent use of gentamicin with potent diuretics should be avoided, since certain diuretics by themselves may cause ototoxicity. In addition, when administered intravenously, diuretics may cause a rise in gentamicin serum level and potentiate neurotoxicity.

USAGE IN PREGNANCY Safety for use in pregnancy has not been established.

See Clinical Considerations section which follows...

Schering

On all in-patient services...
in hospital-acquired gram-negative infections*

Garamycin®
gentamicin sulfate injectable
I.M./I.V.

40 mg. per cc.
Each cc. contains
gentamicin sulfate equivalent
to 40 mg. gentamicin

Also available.
GARAMYCIN® Pediatric Injectable, 10 mg. per cc.

GARAMYCIN® Injectable, brand of gentamicin sulfate U.S.P., injection, 40 mg./cc.
Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin
For Parenteral Administration

> **WARNING**
> Patients treated with GARAMYCIN Injectable should be under close clinical observation because of the potential toxicity associated with the use of this drug.
>
> Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.
>
> GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment.
>
> Monitoring of renal and eighth nerve function is recommended during therapy of patients with known impairment of renal function. This testing is also recommended in patients with normal renal function at onset of therapy who develop evidence of nitrogen retention (increasing BUN, NPN, creatinine or oliguria). Evidence of ototoxicity requires dosage adjustments or discontinuance of the drug.
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> In event of overdose or toxic reactions, peritoneal dialysis or hemodialysis will aid in removal of gentamicin from the blood.
>
> Serum concentrations should be monitored when feasible and prolonged concentrations above 12 mcg./ml. should be avoided.
>
> Concurrent use of other neurotoxic and/or nephrotoxic drugs, particularly streptomycin, neomycin, kanamycin, cephaloridine, viomycin, polymyxin B, and polymyxin E (colistin), should be avoided.
>
> The concurrent use of gentamicin with potent diuretics should be avoided, since certain diuretics by themselves may cause ototoxicity. In addition, when administered intravenously, diuretics may cause a rise in gentamicin serum level and potentiate neurotoxicity.
>
> **USAGE IN PREGNANCY** Safety for use in pregnancy has not been established.

INDICATIONS GARAMYCIN Injectable is indicated, with due regard for relative toxicity of antibiotics, in the treatment of serious infections caused by susceptible strains of the following microorganisms:

Pseudomonas aeruginosa, Proteus species (indole-positive and indole-negative), **Escherichia coli** and **Klebsiella-Enterobacter-Serratia** species.

Clinical studies have shown GARAMYCIN Injectable to be effective in septicemia and serious infections of the central nervous system (meningitis), urinary tract, respiratory tract, gastrointestinal tract, skin and soft tissue (including burns).

Bacteriologic tests to determine the causative organisms and their susceptibility to gentamicin should be performed.

Bacterial resistance to gentamicin develops slowly in stepwise fashion; there have been no one-step mutations to high resistance.

In suspected or documented gram-negative sepsis, GARAMYCIN may be considered as initial therapy. The decision to continue therapy with this drug should be based on the results of susceptibility tests, the severity of the infection, and the important additional concepts contained in the Warning Box. In the neonate with suspected sepsis or staphylococcal pneumonia, a penicillin type drug is usually indicated as concomitant antimicrobial therapy.

GARAMYCIN Injectable has been shown to be effective in serious staphylococcal infections. It may be considered in those infections when penicillins or other less potentially toxic drugs are contraindicated and bacterial susceptibility testing and clinical judgment indicate its use.

CONTRAINDICATIONS A history of hypersensitivity to gentamicin is a contraindication to its use.

WARNINGS See Warning Box.

PRECAUTIONS Neuromuscular blockade and respiratory paralysis have been reported in the cat receiving high doses (40 mg./kg.) of gentamicin. The possibility of these phenomena occurring in man should be considered if gentamicin is administered to patients receiving neuromuscular blocking agents such as succinylcholine and tubocurarine.

Treatment with gentamicin may result in overgrowth of nonsusceptible organisms. If this occurs, appropriate therapy is indicated.

ADVERSE REACTIONS

Nephrotoxicity: Adverse renal effects, as demonstrated by rising BUN, NPN, serum creatinine and oliguria, have been reported. They occur more frequently in patients with a history of renal impairment treated with larger than recommended dosage.

Neurotoxicity: Adverse effects on both vestibular and auditory branches of the eighth nerve have been reported in patients on high dosage and/or prolonged therapy. Symptoms include dizziness, vertigo, tinnitus, roaring in the ears and hearing loss.

Numbness, skin tingling, muscle twitching, and convulsions have also been reported.

Note: The risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.

Other reported adverse reactions, possibly related to gentamicin, include increased serum transaminase (SGOT, SGPT), increased serum bilirubin, transient hepatomegaly, decreased serum calcium; splenomegaly, anemia, increased and decreased reticulocyte counts, granulocytopenia, thrombocytopenia, purpura; fever, rash, itching, urticaria, generalized burning, joint pain, laryngeal edema; nausea, vomiting, headache, increased salivation, lethargy and decreased appetite, weight loss, pulmonary fibrosis, hypotension and hypertension.

DOSAGE AND ADMINISTRATION GARAMYCIN Injectable may be given intramuscularly or intravenously.

For Intramuscular Administration:

PATIENTS WITH NORMAL RENAL FUNCTION*

Adults: The recommended dosage for GARAMYCIN Injectable for patients with serious infections and normal renal function is 3 mg./kg./day, administered in three equal doses every 8 hours.

For patients weighing over 60 kg. (132 lb.), the usual dosage is 80 mg. (2 cc.) three times daily. For patients weighing 60 kg. (132 lb.) or less, the usual dose is 60 mg. (1.5 cc.) three times daily.

In patients with life-threatening infections, dosages up to 5 mg./kg./day may be administered in three or four equal doses. This dosage should be reduced to 3 mg./kg./day as soon as clinically indicated.

*In children and infants, the newborn, and patients with impaired renal function, dosage must be adjusted in accordance with instructions set forth in the Package Insert.

For Intravenous Administration:

The intravenous administration of GARAMYCIN Injectable is recommended in those circumstances when the intramuscular route is not feasible (e.g., patients in shock, with hematologic disorders, with severe burns, or with reduced muscle mass).

For intravenous administration, in adults, a single dose of GARAMYCIN Injectable may be diluted in 100 or 200 cc. of sterile normal saline or in a sterile solution of dextrose 5% in water; in infants and children, the volume of diluent should be less. The concentration of gentamicin in solution, in both instances should normally not exceed 1 mg./cc. (0.1%). The solution is infused over a period of 1 to 2 hours.

The recommended dose for intravenous administration is identical to that recommended for intramuscular use.

GARAMYCIN Injectable should not be physically pre-mixed with other drugs, but should be administered separately in accordance with the recommended route of administration and dosage schedule.

HOW SUPPLIED GARAMYCIN Injectable, 40 mg. per cc., 2 cc. multiple-dose vials for parenteral administration.

Also available, GARAMYCIN Pediatric Injectable, 10 mg. per cc., 2 cc. multiple-dose vials for parenteral administration.

APRIL, 1972
AHFS Category 8:12.28

For more complete prescribing details, consult Package Insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.

*Due to susceptible organisms

SLR-301

Here is program for C-P-T Conference July 26 - 27

The 53rd annual Coller-Penberthy-Thirlby Medical Conference is scheduled July 26-27 at the Park Place Motor Inn, Traverse City. Chairman Laurence P. Skendzel, MD, has planned a varied program to meet the educational needs of practicing physicians.

Following is the schedule of meetings:

Thursday, July 26

9:15 a.m.	Distribution of blood among different kinds of transfused patients with blood
9:30 a.m.	The eyelid as an aid to the diagnosis of systemic disease
9:45 a.m.	The current status of the use of immunosuppressive agents in general medicine
10:00 a.m.	Foreign bodies I have known
10:30 a.m.	Gastrointestinal hemorrhage and shock in sepsis
10:45 a.m.	Cancer of the stomach
11:00 a.m.	Carcinogenesis and epidemiology of gastrointestinal carcinoma
11:15 a.m.	Cancer of the tongue
11:30 a.m.	Subcutaneous mastectomy and prosthetic reconstruction
11:45 a.m.	Real plastic surgery, or how to remove desmoid tumors
2:00 p.m.	Panel on intensive care units
3:15 p.m.	A high risk obstetric service
3:30 p.m.	Regional perinatal centers
3:45 p.m.	Families of high risk infants
4:00 p.m.	Parathyroid hormone assay in clinical practice
4:15 p.m.	Clinical experience with parietal cell vagotomy without drainage
4:30 p.m.	The quality of surgical care—a follow-up
6:30 p.m.	Cocktails and banquet, with speaker Jack Bensley

Friday, July 27

9:00 a.m.	Trophoblastic neoplasms and their management
9:15 a.m.	The chin-on-chest deformity of ankylosing spondylitis
9:30 a.m.	The operative treatment of chronic active pancreatitis
9:45 a.m.	Health Care and the private foundations
10:00 a.m.	Psychological influences on drug responses
10:30 a.m.	New trends in the surgical treatment of congenital heart disease
10:45 a.m.	Program to be determined
11:00 a.m.	Revascularization of the lower extremities
11:15 a.m.	Tracheostomy and aspiration pneumonia
11:30 a.m.	Comparative anatomy of health services.

Honored guests will include Mrs. F. A. Coller; John J. Coury, MD, MSMS president; Andrew D. Hunt, Jr., MD, Dean, MSU College of Human Medicine; Edgar A. Kahn, MD, professor emeritus of surgery, The U-M Medical Center; Reed M. Nesbit, MD, asociate director of the Joint Commission on Accreditation of Hospitals, Chicago, and Harry A. Towsley, MD, professor emeritus of pediatrics, The U-M Medical Center.

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Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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Ali A. Behzadnia, MD, 11501 Southfield, Allen Park, 48101
Carl P. Brandt, MD, 1421 Woodlawn, SE Grand Rapids, 49506
George W. Brown, MD, 212 S. Redbud Trail Buchanan 49107
Paul L. Chan, MD, 1420 Center Ave., Bay City 48706
Eli A. Coats, MD, 120 Waukazoo Dr., Holland 49423
Alice S. Crosby, MD, 1450 Hitching Post Rd., East Lansing 48823
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Sheila K. Dhandha, MD, 3901 Beaubien, Detroit 48201
Philip Dorman, MD, Henry Ford Hospital, Detroit 48202
Jerome H. Dykstra, MD, 680 S. Washington, Holland 49423
Donald M. Fix, MD, 4360-19 Crooked Tree Rd., SW, Grand Rapids 49509
N. Froozan, MD, 5990 N. Wayne Rd., Westland 48185
William G. Grannis, MD, 22101 Moross Rd., Detroit 48236
B.G. Gatmaitan, MD, 1857 Shirley Ln. B-3, Ann Arbor 48105
Richard Granse, MD, Sparrow Hospital, Lansing 48902
Muriel Harris, MD, 222 E. Maple #212, Birmingham 48011
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Joseph C. Horozaniecki, MD, LaCroix Hospital White Pine 49971
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Juh-Yih Jean, MD, 125 N. Hanselman St., Bad Axe 48413
Irving J. Kane, MD, VA Hospital, 1500 Weiss St. Saginaw 48605
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Suresh P. Khurana, MD, 22101 Moross Rd., Detroit 48236
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Betty Koshy, MD, 815 Highland, St. Joseph 49085
Naim Koymen, MD, 1631 Gull Rd., Kalamazoo 49001
Chung No Lee, MD, 143 Seminole St. Pontiac 48053
Satyabrata Maitra, MD, 7845 Middlebelt, Romulus 48174
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Franklin D. McDonald, MD, 432 E. Hancock Detroit 48201
William D. Myers, MD, 22341 W. Eight Mile Rd. Detroit 48219
Frances E. Noe, MD, 6767 W. Outer Dr., Detroit 48235
Jan Han Oh, MD, 2110 16th St., Bay City 48706
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Lubomir J. Valenta, MD, 2962 Horizon Ave., East Lansing 48823
Wm. E. Van Eerden, MD, 6850 Division Ave., S. Grand Rapids, 49508
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Arthur Wierenga, MD, 2641 Clinton Rd., Jackson 49201
Robert M. Williams, MD, P.O. Box 181, Grayling 49738
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James F. Shetlar, MD, 117 Hubinger, Frankenmuth, 48734
Hyun Won Shin, MD, 1600 N. Michigan Ave., Saginaw, 48602
Ronald A. Siwik, MD, 3406 Davenport, Saginaw, 48602
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Detroit lags behind other U.S. cities in MD / patient ratio

The metropolitan Detroit area, including the counties of Wayne, Oakland and Macomb, is last among the 10 largest metropolitan centers in the U.S. in its numbers of physicians to population. That is according to a recent study of the Michigan Health Council.

There is only one MD or DO for every 591 persons in the Detroit area, according to the MHC study. The average for the 10 largest metropolitan areas is one physician per 442 population, with New York holding the best ratio of one per 348.

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MSMS survey finds 92.7% of primary care MDs surveyed are accepting new patients

Ninety two and seven-tenths percent of Michigan primary care physicians included in a recent MSMS survey reported that they are accepting new patients.

Eighty three and five-tenths percent replied that they are accepting new Medicaid patients.

Those were the major findings of MSMS's own survey on the availability of medical care made in April and May by the MSMS Bureau of Economic Information.

Details of the survey are summarized below.

Survey Purpose: To recognize the availability of and access to primary care physicians.

Objective: To have meaningful data on the availability of care. To share the gained information and knowledge with appropriate parties.

Methodology: A four county sampling of 676 primary care physicians — family practitioners, pediatricians, obstetricians-gynecologists, internists, and general surgeons — was surveyed.

The survey was via a first class mailing. It included a letter requesting assistance from the Chairman of the MSMS Council, and the stamped, self-addressed return post card questionnaire.

The survey was sent on April 23 to the primary care physician members (as defined above) of the following counties: Kent, Jackson, Bay-Arenac-Iosco, and parts of Wayne.

Tabulation: Surveys were accepted through May 7 and were manually processed. Because of missing information on some returned surveys, answers were supplied based on interpretation of data given. This was not possible on some surveys, and they were eliminated from the tabulations.

Findings:

1. Of the 418 usable surveys, 399 indicated they provided office-based patient care.
2. Of those who provide patient care, 370 (or 92.7%) accept new patients.
3. Of the 370 responding physicians who accept new patients, 309 (or 83.5%) accept new Medicaid patients.
4. 94.7% of the physicians who perform office-based patient care provide medical care for Medicaid patients.
5. 88.0% of the respondents indicated they signed the Medicaid physician ID form.

Below is the survey as it was sent out to those physicians surveyed.

MSMS Survey On Availability Of Care
April, 1973

1. Do you provide office-based patient care?
   yes__________ no__________
   What county?__________
   What specialty?__________
2. Do you accept any new patients?
   yes__________ no__________
   If yes, how many per month? __________
3. Do you accept new Medicaid patients?
   yes__________ no__________
   If yes, how many per month? __________
   If not, why? __________
4. Do you care for Medicaid patients?
   yes__________ no__________
   What percent of your patients are on Medicaid?__________%
5. Did you sign the Medicaid physician ID form?
   yes__________ no__________

Please Return By April 30, 1973

TOTAL

Specialties — Surgery - 83; OB-GYN - 69; Pediatrics - 41; Internal Medicine - 91; General Practice - 123; other - 4; retired - 7; TOTAL RESPONSE - 418

1.	Yes — 399 (95.5%)	No — 19 (4.5%)
2.	Yes — 370 (92.7%)	No — 29 (7.3%)
3.	Yes — 309 (83.5%)	No — 61 (16.5%)
4	Yes — 378 (94.7%)	No — 21 (5.3%)
5	Yes — 351 (88.0%)	No — 48 (12.0%)

Counties	Surveys Mailed	Respondents	Return Percentage
Wayne	296	141	47.6%
Kent	248	193	77.8%
Jackson	76	48	63.1%
Bay-Arenac-Iosco	56	36	64.3%
Unknown		6	
TOTAL	676	424	62.7%

SURVEY RESULTS
In percentages

	KENT	WAYNE	JACKSON	BAY
Question 1				
Yes	94.8%	96.5%	93.8%	97.2%
No	5.2	3.5	6.2	2.8
Question 2				
Yes	94.0	93.4	86.7	91.4
No	6.0	6.6	13.3	8.6
Question 3				
Yes	89.5	82.7	69.2	71.9
No	10.5	17.3	30.8	28.1
Question 4				
Yes	97.8	91.8	95.6	94.3
No	2.2	8.2	4.4	5.7
Question 5				
Yes	90.2	85.3	84.4	91.4
No	9.8	14.7	15.6	8.6

KENT

Specialities — Surgery - 39; OB-GYN - 37; Pediatrics - 19; Internal Medicine - 42; General Practice - 47; other - 4; retired - 5.

1.	Yes — 183 (94.8%)	No — 10 (5.2%)
2.	Yes — 172 (94.0%)	No — 11 (6.0%)
3.	Yes — 154 (89.5%)	No — 18 (10.5%)
4.	Yes — 179 (97.8%)	No — 4 (2.2%)
5.	Yes — 165 (90.2%)	No — 18 (9.8%)

WAYNE

Specialities — Surgery - 32; OB-GYN - 23; Pediatrics - 13; Internal Medicine - 32; General Practice - 41.

1.	Yes — 136 (96.5%)	No — 5 (3.5%)
2	Yes — 127 (93.4%)	No — 9 (6.6%)
3	Yes — 105 (82.7%)	No — 22 (17.3%)
4	Yes — 123 (91.8%)	No — 13 (8.2%)
5	Yes — 116 (85.3%)	No — 20 (14.7%)

BAY

Specialties — Surgery - 6; OB-GYN - 3; Pediatrics - 4; Internal Medicine - 5; General Practice - 17; retired - 1

1	Yes — 35 (97.2%)	No — 1 (2.8%)
2	Yes — 32 (91.4%)	No — 3 (8.6%)
3	Yes — 23 (71.9%)	No — 9 (28.1%)
4	Yes — 33 (94.3%)	No — 2 (5.7%)
5	Yes — 32 (91.4%)	No — 3 (8.6%)

JACKSON

Specialities — Surgery - 6; OB-GYN - 6; Pediatrics - 5; Internal Medicine - 12; General Practice - 18; retired - 1.

1	Yes — 45 (93.8%)	No — 3 (6.2%)
2.	Yes — 39 (86.7%)	No — 6 (13.3%)
3	Yes — 27 (69.2%)	No — 12 (30.8%)
4	Yes — 43 (95.6%)	No — 2 (4.4%)
5	Yes — 38 (84.4%)	No — 7 (15.6%)

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UNIVERSITY HEALTH PHYSICIAN—Athletic Medicine Coordinator: Staff position available for M.D. in Detroit. Position includes responsibility to Athletic programs of the University plus general clinic duties. Competitive salary and fringe benefits including retirement and disability programs offered. Experience in managing athletic injuries desirable. For information send vitae to Andrew J. Smith, Jr., M.D., Director, Health Services, Wayne State University, Detroit, Michigan 48202. The University is an Affirmative Action/Equal Opportunity Employer.

STAFF PSYCHIATRISTS: Community oriented State of Michigan agency. Affiliated with Wayne State University (faculty appointment available); active teaching program ongoing in all disciplines. Salaries range from $25,600-$33,500 (depending on qualifications) plus liberal fringe benefits. Apply: Medical Director, Detroit Psychiatric Institute, 1151 Taylor, Detroit, Michigan 48202.

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PRECAUTIONS: Prolonged dosage of androgen may result in sodium and fluid retention This may present a problem, especially in patients with compromised cardiac reserve or renal disease In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

CONTRAINDICATIONS: Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast Contraindicated in the presence of severe liver damage.

WARNINGS: If priapism or other signs of excessive sexual stimulation develop, discontinue therapy In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastic breast carcinoma. If this occurs, the drug should be discontinued.

ADVERSE REACTIONS: Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastic breast carcinoma This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia

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In memoriam

Charles R. Baber, MD
Sturgis

Charles R. Baber, MD, long time Columbus, Ohio, surgeon, died April 27 at the age of 61. He had resided in Sturgis the past five years.

Doctor Baber was a graduate of the Ohio State University school of medicine and was a member of the American College of Surgeons. He founded the Columbus, Ohio, Surgery Society and practiced there for 26 years. He was a member of the Ohio State Medical Society, as well as MSMS.

A. O. Brown, MD
Detroit

A Detroit-area ophthalmologist for more than 50 years, A. O. Brown, MD, died May 16 at the age of 82.

Doctor Brown was former chief of staff at Providence Hospital, Southfield, and received presidential citations for his work with the Selective Service during World War II.

Doctor Brown was a graduate of the Detroit College of Medicine, a fellow of the American College of Surgeons, and a member of the American Academy of Ophthalmology and Otolaryngology, the Michigan Ophthalmological Society and the Detroit Ophthalmological Club.

William H. Hutto, MD
Burt Lake

A long-time Kokomo, Ind., physician who had been practicing in recent years in the Cheboygan area, died May 14 at the age of 61.

Doctor Hutto, a graduate of the University of Indiana Medical School, had practiced in Kokomo for 32 years. He had had a summer home on Burt Lake since 1940.

Doctor Hutto, a surgeon, was a member of the International College of Surgeons.

James E. Lofstrom, MD
St. Clair Shores

James E. Lofstrom, MD, radiologist and art collector, died May 11 at the age of 63. Doctor Lofstrom had been chairman of the Radiology Department at William Beaumont Hospital, Royal Oak, from 1965 to 1970, and before that headed the Radiology Department at Detroit General Hospital. He was a former chairman of the WSU School of Medicine Radiology Department.

Doctor Lofstrom was a graduate of the University of Minnesota medical school and was a member of the Detroit, American and North American radiological societies. He was a former member of the American Cancer Society board of directors and had been consultant to the Oak Ridge Institute of Nuclear Studies.

Constantine P. Mehas, MD
Orchard Lake

Constantine Peter Mehas, MD, Orchard Lake generalist, died May 28 at the age of 66.

Doctor Mehas was a graduate of the University of Cincinnati medical school and was affiliated with William Beaumont Hospital in Royal Oak and St. Joseph Mercy and Pontiac General hospitals in Pontiac. He was a fellow of the American College of Chest Physicians.

C. P. Polentz, MD
Oak Park

Detroit-area internist Charles Paul Polentz, MD, died May 1 at the age of 61.

Doctor Polentz was a graduate of Wayne State University School of Medicine and was on the staff of Mt. Carmel Mercy Hospital, Detroit. He was a native of Scranton, Pa.

William A. Thompson, MD
Detroit

Retired Detroit generalist William Arthur Thompson, MD, died May 1 at the age of 90.

Doctor Thompson practiced in Detroit from 1924 to 1964 and was former chief of staff at Parkside Hospital, where he also was chairman of the medical section.

He was a board executive emeritus of the NAACP, of which he was a life member, and had served during World War II as vice chairman of the Detroit Branch of Selective Service. He also had been a member of the Citizens Advisory Committee for Detroit Public Schools and active in Detroit-area Methodist Churches.

Doctor Thompson was a native of Tennessee and was graduated from Meharry Medical College.

John A. White, MD
Big Rapids

John A. White, MD, Big Rapids surgeon for 36 years until his retirement in 1972, died May 7 at the age of 68. Doctor White was a native of Cleveland, Ohio, and was graduated from Marquette Medical School.

Doctor White was chief of staff several times of Big Rapids Community Hospital, and had been president and secretary of the Mecosta-Osceola-Lake Counties Medical Society. He was a fellow of the International Academy of Proctology.

MSMS studies postgraduate training

MSMS Participates in Study of Funding, Other Problems re Interns, Residents

The Spring meeting of the MSMS House of Delegates approved a report of an ad hoc committee which included the recommendation that:

"The MSMS Council should continue its study of a possible proposal to the Michigan legislature requesting state appropriations for postgraduate training-programs for interns and residents."

That recommendation and 13 others were submitted to the House by the MSMS ad hoc committee charged to consider ways to turn around the emigration of medical graduates from Michigan to other states. The ad hoc committee report from George Koepke, MD, Ann Arbor, chairman, offered the following supporting comments:

"Alternative methods of financing postgraduate medical training are being sought in Michigan and other states. There is support in various circles in Michigan for a program in operation in Indiana where the legislature does fund intern and resident programs. Reports from Indiana indicate the program is a factor in retaining more Indiana graduates in Indiana. State appropriations, it is believed, would enable teaching hospitals to expand and improve their teaching programs."

The House adopted all 14 recommendations, which now have been referred by the MSMS Council to the Education Liaison Committee and other committees for implementation.

Some of the elements of a possible Michigan proposal re state funding were outlined to the MSMS Council in the spring. The Council voted to appoint several members to confer with representatives from other allied interests to study the matter further. Appointments have been made and instruction given to further develop the proposal.

Named by MSMS Council Chairman Robert M. Leitch, MD, as the MSMS representatives were Cecelia Hissong, MD, Dearborn; John W. Moses, MD, Southfield; Lewis E. Simoni, MD, Flint; Lee B. Stevenson, MD, Farmington; Robert M. Stow, MD, Lansing and J. H. Tisdel, MD, Port Huron.

The following article described the patterns for graduate medical training in the United States, and the many major problems, and then deals with graduate medical education in Michigan.

MSMS members are invited to comment on the report, and to offer suggestions to members of the MSMS Council or to write their comments to Robert M. Leitch, MD, Chairman, MSMS Council.

Five Problems Discussed in Connection With Graduate Medical Education in USA

Introduction

Medical education traditionally has been divided into three segments: undergraduate medical education, graduate medical education, and postgraduate or continuing medical education.

Undergraduate medical education is that period of formal training which begins with entry into professional school and ends with granting of the M.D. or D.O. degree.

The term *graduate medical education* refers to the training a physician receives after graduation from professional school but before entry into practice. It encompasses internship, residency, and fellowship training and is that period during which specialization or subspecialization occurs.

Postgraduate medical education is the period of continued study which physicians must participate in while in practice if they are to maintain their competence. In contrast to the undergraduate and graduate phases, it is often conducted on a rather informal and highly individualized basis with the practicing physician himself determining the type and extent of his educational activities.

This proposal will deal with the second of these three phases—graduate medical education. It will outline a plan designed to improve both the quality of graduate medical education in Michigan and the method of financing this period of training. The ultimate aim of the proposal is to provide more and

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better trained physicians to deliver health care to our populations.

While the proposal deals primarily with internship, residency, and fellowship training it must be remembered that most educators believe medical education should be viewed as a continuum with each phase intimately related to the others.[1] For this reason, any proposed change in our system of graduate medical education must be evaluated in terms of its potential effect on both undergraduate and continuing medical education, and any system designed to govern and finance graduate medical education must promote rather than hinder their conduct.

Graduate Medical Education in the United States

Graduate medical education now begins with a one-year internship following graduation from medical school. The internship is served in a hospital and may involve rotation through a variety of specialty services or concentration in a single area of medicine. It permits the new physician to function in a semi-independent manner. Internships are now financed by hospitals with revenue derived primarily from patient-generated funds.

Hospitals are approved for internship training by the Council on Medical Education of the American Medical Association (AMA) upon the recommendation of a joint Internship Review Committee which has representation from the AMA Council on Medical Education, the Association of American Medical Colleges (AAMC), the American Hospital Association (AHA), the Federation of State Medical Boards, and the field of general practice.

By June 30, 1975 all free-standing internships will be eliminated and the first year of graduate medical education, which the internship now represents, will be coordinated with a residency training program and will become the responsibility of the appropriate residency review committee.

Following internship, most physicians enter a residency training program. Residencies are hospital-based and are of from 2 to 5 or more years in duration. During residency training, the physician specializes, concentrating on a single field such as general surgery, internal medicine, pediatrics, or obstetrics and gynecology. Most residencies are financed by hospitals with funds generated from patient care. As with internships, university medical schools may or may not participate in the coordination of this phase of training. For example, of the total of 42,293 residency positions filled in the United States on September 1, 1971, about 10% were in hospitals with no university medical school affiliation.[2] Of the remaining 90%, many were in hospitals with only a relatively minor university affiliation.

Residency training is coordinated at the national level by a variety of residency review committees organized along medical specialty lines. These committees review and approve hospitals for residency training in the discipline involved. In order to minimize the fragmentation of control of residency education inherent in a system involving many specialty-oriented residency review committees, a Liaison Committee on Graduate Medical Education (LCGME) has recently been formed.[3] The parent bodies of the LCGME are the AMA, AAMC, American Board of Medical Specialties, Council of Medical Specialty Societies, and AHA. The LCGME will seek to become the official accrediting agency for graduate medical education in the United States.

Following residency training, some physicians may elect to take one or more years of fellowship training. Some fellowships provide additional clinical training in a subspecialty area of medical practice such as allergy, hematology, or gastroenterology; others are designed to provide a highly-specialized research experience. Some are offered by univeristy medical centers while others are conducted at community hospitals. A variety of funding mechanisms are employed, ranging from use of patient-generated funds to use of training grant funds from national organizations. Responsibility for control of the content and duration of fellowship training and for approval of individual programs varies according to the type and purpose of the fellowship. There is no national review mechanism comparable to those guiding residency programs.

Editor's Note: This article contains information collected by five Michigan physicians along with some evaluations made by these men. *Michigan Medicine* expresses its appreciation to Doctors Calvin Dykman, Roland G. Hill, Joseph A. Rinaldo, Jeoffrey K. Stross, and Neal A. Vanselow.

Problems associated with graduate medical education in the United States

1. Fragmented Control

Graduate medical education in the United States has been the subject of increasing criticism in recent years.[1-4] One major area of concern has been the fragmented way in which it is controlled. As opposed to undergraduate medical education which is the responsibility of university medical schools, responsibility for the conduct of graduate medical education is shared by hospitals, service chiefs, residency review committees, specialty and subspecialty boards, state licensure boards, and third party payers.

Graduate medical education is hospital-based rather than university-based and is financed primarily through funds generated by patient care. For this reason, hospital administrators exercise considerable control over the number of trainees graduate education programs will accept and over the quality of the training programs themselves.

Within a hospital, control of graduate education is shared with service chiefs who have considerable influence on the content of the training program in their respective specialty areas. In some cases this has resulted in variation in quality of training programs within a hospital and disproportionate flow of hospital financial and other resources to programs run by "strong" chiefs. Because the traditional impetus for size and type of house officer training programs has been at the department or service level, the effect of one program on the others has often been left to chance. In recent years an attempt to remedy this situation has led to promotion of the concept of "corporate responsibility" for graduate medical education. This concept requires that individual program directors or service chiefs act together with hospital administration to establish institutional priorities for graduate medical education so that the limited resources available can be utilized to respond to the needs of society and of the institution as a whole.

As contrasted with undergraduate medical education which is controlled by universities, the influence of the university on graduate medical education is variable.

University medical schools exert considerable influence on training programs in hospitals which they own and operate. Their influence on programs in "university affiliated hospitals" varies with the nature and extent of the affiliation, and they exercise no influence on programs run in non-affiliated hospitals. The recent tendency to view all phases of medical education as a continuum has led the Association of American Medical Colleges to recommend that university medical centers assume responsibility for all graduate medical education in a fashion similar to the responsibility they have traditionally assumed for undergraduate medical education.[5]

The control of graduate medical education in the United States is further fragmented by the role played by residency review committees, specialty boards, and state licensing boards.

As previously mentioned, a plethora of residency review committees control the duration and content of training programs and are vested with the power to approve individual programs. Autonomous specialty and subspecialty boards are empowered to certify individual physicians as specialists in a particular area of medical practice. For this reason they exercise an indirect but not insignificant degree of control over the programs which train physicians in those specialties. State licensing boards traditionally require at least one year of graduate medical education prior to granting a license to practice medicine and thus exert some control over portions of graduate training programs. The fragmentation of responsibility resulting from the variable roles played by residency review committees, specialty boards, and state licensing boards is further magnified by the fact that separate boards and committees exist for the allopathic and osteopathic medical professions.

Third-party payers represent another element which must be considered when discussing the control of graduate medical education. In recent years governmental and private insurance carriers have demonstrated an increasing tendency to specify which services performed by residents will qualify for reimbursement under their programs. Since patient care funds received from third parties are the major source of financing for most training programs, the influence of third parties on program content has been significant.

2. *Inappropriate Financing*

Graduate medical education programs contain both service and educational aspects. In most hospitals house officers provide services which are of major value to patients. At the same time, they are students who are working toward certification in their chosen specialty or subspecialty field.

At the present time, most graduate education programs are financed almost exclusively from funds generated from patient care.[4] Few would argue that it is inappropriate to finance the service aspects of a house officer program from this source; however, there is increasing concern over the financing of the educational component of training programs from funds provided by sick patients. Many believe that the educational costs of graduate medical education should be borne by the community at large through its tax-paying constituency since the benefits accrue to all of society.

Third-party payers have supported this philosophy and have taken steps to limit the funds available for house officer training. In Pennsylvania for example, the Insurance Commissioner has stated that the portion of cost applicable to the education and training of interns and residents should no longer be the unlimited responsibility of patients or Blue Cross making payments on their behalf.

In Michigan, Blue Shield has initiated action which could prevent reimbursement for services rendered by interns and residents as opposed to those rendered by attending physicians.[6]

The controversy over financing has threatened a crisis in graduate medical education. If it is inappropriate to finance the educational aspects of these programs from patient care funds as most believe, a new source of revenue must be found. If it is not, house officer programs will either be reduced in number or will become service-oriented with a greatly reduced educational component. The result will be poorer quality medical care for our citizens.

3. *Variation in quality*

The quality of graduate medical education in the United States varies considerably from hospital to hospital. One measure of this variation is the percentage of foreign medical graduates in training in various institutions. For a variety of educational and cultural reasons, the average graduate of a foreign medical school is considered to be of poorer quality than the average graduate of an American or Canadian medical school. In September 1971, foreign medical graduates occupied 62% of the filled residency positions nationally in non-affiliated hospitals. In contrast, foreign medical graduates accounted for only 28% of the filled residency positions in hospitals affiliated with university medical schools.[2]

There may also be considerable variation in the quality of graduate training programs offered within a single hospital. As previously noted, hospital resources often are diverted in disproportionate fashion to programs run by "strong" service chiefs. When this is the case, other programs in the same institution may suffer.

The variation in quality which characterizes graduate medical education in the United States today results from a variety of factors. A major one is the fragmentation of control of internship and residency training and the absence of a body which can effectively monitor the quality of programs on an ongoing basis. Residency review committees attempt to do the latter but lack the staff to do it satisfactorily. Inappropriate financing of graduate medical education is another important element.

4. *Inadequate response to public need for Physician manpower*

The ability to respond to public need in terms of type and number of physicians produced has been diminished by the fragmented control and inappropriate financing of our system of graduate medical education.

The number and type of physicians which the system produces is the result of an uncoordinated series of decisions made by a variety of residency review committees, by hospitals, and by individual service chiefs. Availability of financing, prestige, and the service needs of an individual hospital program are often the major determinants of whether or not a particular residency program will be offered. There is no central coordinating body which can adjust the output of various training programs to the needs of a particular state, region, or of the nation as a whole.

This problem is illustrated by data on the availability of residency positions in the United States for the 1973-74 academic year.[2] In spite of the fact that there is a generally recognized need for more primary care physicians, residencies in 4 primary care disciplines (family practice, general practice, internal medicine, and pediatrics) accounted for only 28% of the total residency positions offered in the United States. There were more residency positions offered in surgery, a field considered by many to be overpopulated, than the total of positions offered in family practice, general practice, and pediatrics combined.

5. *Inadequate inservice evaluation of graduate physicians*

There is little formal evaluation of the performance of the graduate physician during his internship, residency, or fellowship training program.

Many graduate trainees do not become aware of the areas in which they are deficient until they complete their training and fail to pass the cer-

TABLE I: Kind and Number of Residencies Offered in Michigan 1972-73

	Specialty Program	Number of Programs in State	Number of Positions in State
1.	Anesthesiology	5	58
2.	Colon & rectal surgery	1	2
3.	Dermatology	3	40
4.	Family practice	3	48
5.	Forensic pathology	1	3
6.	General practice	6	47
7.	Internal medicine	20	454
8.	Neurological surgery	3	28
9.	Neurology	3	32
10.	Obstetrics & gynecology	21	212
11.	Occupational medicine	4	11
12.	Ophthalmology	6	64
13.	Orthopedic surgery	6	84
14.	Otolaryngology	3	37
15.	Pathology	25	177
16.	Pediatric allergy	3	7
17.	Pediatrics	10	125
18.	Pediatric cardiology	1	4
19.	Physical medicine and rehabilitation	2	15
20.	Plastic surgery	4	14
21.	Preventive medicine	1	*
22.	Psychiatry	11	223
23.	Public health	*	
24.	Radiology (Diagnostic and therapeutic)	15	172
25.	General surgery	22	371
26.	Thoracic surgery	2	13
27.	Urology	7	41
	Total allopathic residency programs & positions	188	2,282
	Total osteopathic residency positions	Unknown	339
	TOTAL		2,621

*no figure given

tifying examination administered by a specialty board. By then it is often too late to develop a program to remedy these deficiencies. The result is an inadequately trained physician who lacks formal certification in the field in which he trained and whose practice may be restricted for this reason. The lack of formal evaluation procedures in many graduate training programs can be contrasted with the situation in undergraduate medical education where student progress and performance is evaluated at regular intervals.

Michigan Problems in Graduate Medical Education Merit Attention

The problem associated with graduate medical education in the United States as a whole also applies to Michigan.

Michigan has taken no unique steps to combat the fragmentation of control, inappropriate financing, variation in quality from program to program, unresponsiveness to public need for physicians, and lack of inservice evaluation of trainees which characterize programs elsewhere. Any program designed to improve the quality and quantity of graduate physician education in Michigan must address itself to these problems.

In 1971-72 Michigan ranked sixth in the nation (2) in both number of allopathic internships offered (667) and the number of internship positions filled (516). It also ranked sixth in the nation in number of allopathic residencies offered (2,225), but dropped to seventh in terms of number of residency positions filled (1,855). Data for osteopathic house officers in Michigan show a similar trend. (The kind and number of residencies offered in Michigan in 1972-73 is given in Table 1). Little data are available on fellowship positions offered and filled.

Michigan's ranking in terms of both number of internship and residency positions offered and number filled is proportional to its ranking in terms of population. In the 1970 census Michigan had a population of 8,800,000 and ranked as the seventh most populous state.

Figure 1 indicates that in 1971 Michigan ranked close to the national average in terms of percentage of available internship and residency positions which were filled. A greater percentage of internship and residency positions in Michigan were filled with foreign medical graduates than was the case nationally. In 1971 foreign medical graduates occupied 52% of the filled internships in Michigan as compared with a national average of 33%.[2] Similarly, 46% of the filled positions in Michigan residencies were occupied by foreign medical graduates as compared to a national average of 32%.

These data suggest that an influx of foreign medical graduates is responsible in large part for Michigan's ability to approach the national average of percentage of house officer position filled.

Furthermore, of the 443 physicians granted new licenses in Michigan from July, 1972 to January, 1973, 120 (27%) were foreign medical graduates.

The information pertaining to American and Canadian trained graduates further demonstrates Michigan's problem. Michigan is in negative

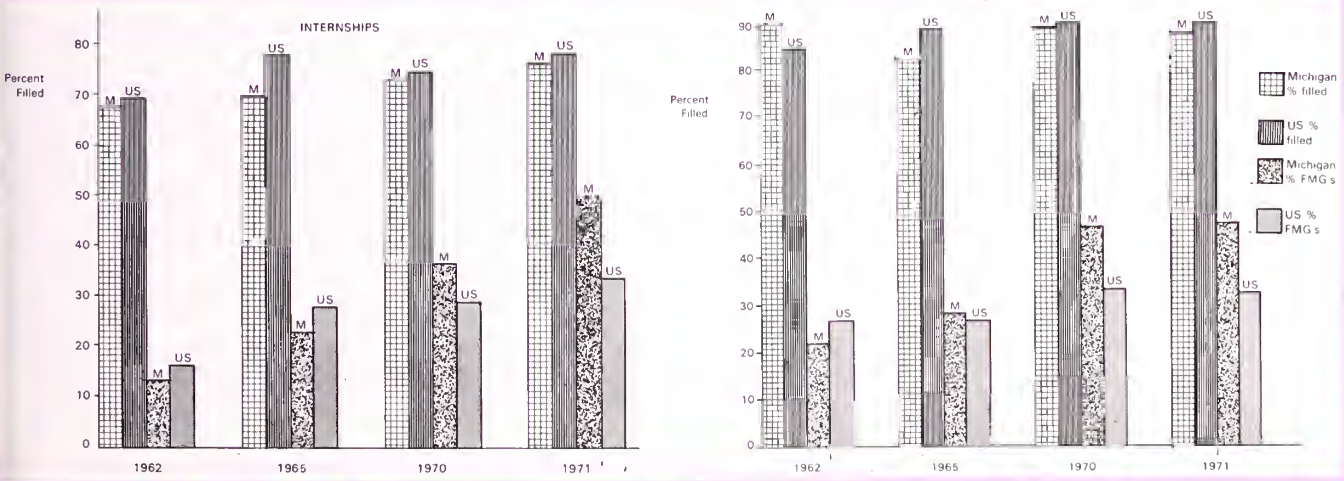

FIGURE 1. Internships and residencies in Michigan and the U.S., percent filled in recent years

TABLE II. University of Michigan Affiliated Hospital Residency Training—1947-1970 Location of Practice of Trainees

Total Trained	1156
Michigan residents	411(36%)
Non-Michigan residents	745(64%)
Number of total trainees staying in Michigan to practice	764(66%)
Number of Michigan residents staying in Michigan to practice	332(44%)
Number of non-Michigan residents staying in Michigan to practice	432(56%)

balance when one compares the number of graduates from American or Canadian medical schools who are in house officer programs in the state with the number of graduates of Michigan medical schools in house officer programs throughout the United States. In 1971, for example, there were 1,335 interns and residents in the United States who had received their M.D. degree in Michigan. In comparison, in the same year, 1,288 graduates of American or Canadian medical schools were taking internship or residency training in Michigan hospitals.[2] For that year, Michigan had "exported" 47 physicians to other states. At the same time, 18 other states were enjoying a significant "import" (50 or more physicians, some as high as 3,000) from other states.

There were 31 states who had a more favorable "balance" than did Michigan. This is not an envious position for the 7th most populous state.

The critical importance which graduate training programs have is their effect on physician distribution in the region in which they are conducted. It has been stated that there is a high correlation between the place of graduate medical education and the place of physician practice.[4] Data obtained from community hospitals affiliated with the University of Michigan Medical School support this observation, indicating that 66% of the 1,156 resident physicians who trained in these hospitals between 1947 and 1970 remained in Michigan to practice Table II. Of the 764 trainees who stayed in Michigan, 332 had been state residents, but 432—a nearly equal number—were added from other states. In contrast, only 50% of the graduates of the University of Michigan and Wayne State University medical schools over the past 50 years have remained in Michigan to practice medicine Table III. The location of a physician's graduate program seems to be a greater determinant of his place of ultimate practice than does the location of his medical school.

In summary, Michigan has not solved any of the serious problems which face graduate medical programs in the United States. More importantly, however, Michigan is losing physician manpower to other states. Michigan supplies more physicians to graduate programs elsewhere than it receives from other states and Canada. The importance of this negative balance is the strong relationship of location of a physician's graduate program to location of his ultimate practice.

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TABLE III. University of Michigan and Wayne State University Medical Schools' Graduates Total and Percentages Practicing in State of Michigan

	Total Phys	Prior 1915	1915 -19	1920 -24	1925 -29	1930 -34	1935 -39	1940 -44	1945 -49	1950 -54	1955 -59	1960 -64	1965 -67
UM Total Graduates	5963	142	120	257	431	535	447	632	499	607	891	858	544
WSU Total Graduates	2888	76	66	70	117	218	321	402	269	297	327	459	266
Grand Total	8851	218	186	327	548	753	768	1034	768	904	1218	1317	810
UM Grads in Michigan	2677	32	43	106	181	232	192	290	217	320	434	407	223
WSU Grads in Michigan	1952	57	46	50	98	168	248	285	157	215	220	273	135
Total UM & WSU Grads in Mich	4629	89	89	156	279	400	440	575	374	535	654	680	358
%UM & WSU Grads in Mich	52.3%	40.8%	47.8%	47.7%	50.9%	53.1%	57.3%	55.6%	48.7%	59.2%	53.7%	51.6%	44.2%

Source Medical School Alumni, 1967, Special Statistical Series

President's page

John J. Coury, MD
MSMS President

At the recent AMA House of Delegates meeting, I heard two reports that impressed me and I would like to share portions of each . . .

Russell B. Roth, MD, of Erie, Pa., is his inaugural address as the new AMA president offered these observations:

"The individual physician can do little about the obligations and responsibilities on his own and only through the collective actions of organized physicians can these jobs be done.

"'Unless individual physicians contribute, our broader responsibilities would indeed pass by default to those who would be delighted to shoulder them for us.

"We must continue to recognize the importance of a collective defense of excellence and professionalism in public service.

"As critics carp, gnats buzz, and gadflies sting decade after decade, the AMA forges steadily ahead, making progress. Clearly our profession has not been stalled at any crossroads.

"Our profession does indeed have a multitude of broad societal obligations and responsibilities which increase in scope and number as our capacities increase to do good and useful things for people.

"Physicians, instead of asking, 'What does the medical society do for me?' should be asking, 'How may I be responsive to the many demands which are being made upon the profession of which I am a part?'

"Fellow doctors instead of asking 'Why should I pay dues to the AMA?' should ask 'How can I do my share?'"

* * *

Specific illustrations of AMA activities were reviewed for the AMA delegates by Ernest B. Howard, MD, AMA executive vice-president, in his annual report:

"The number and quality of working programs are impressive—improving health care services in the nation's jails, Project USA, education for driver license examiners, a $300,000 loan program to help physicians return to practice after the tropical storm in Pennsylvania, practice management seminars, regional programs to train medical directors and administrators of long-term care facilities, a clearinghouse on financial information for students in health careers, new emphasis on speakers and leadership training seminars, growing membership insurance opportunities, publication of *Prism*, etc.

"Scientific programs include a new edition of *AMA Drug Evaluations*, a new edition of *Current Procedural Terminology*, four publications on pollution for physicians, a book for physicians titled *Human Sexuality*, development of self-assessment tests and a national accreditation program for continuing medical education, greater emphasis on continuing education courses at the Conventions, growing participation in the Physician's Recognition Award, an educational program on hypertension."

* * *

As a member of the MSMS delegation to the AMA House and as president of MSMS, I have more relations with the AMA than most Michigan doctors. I can assure you that every member physician can be proud of the record of continuing accomplishments of the AMA House, the committees, councils, commissions, and staff.

We are the AMA so let's not stand back and complain. Let's work individually and as a state society to further improve the AMA.

Please send me your positive suggestions and I'll discuss them with our AMA delegation and relay them to the appropriate officers and executives of our AMA.

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The Publication Committee of the MSMS Council is the editorial board of *Michigan Medicine* and advises the Council and the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

Borgess Hospital is a 454 bed hospital and research center offering a complete range of general and specialized medical and surgical services to the residents of southwest Michigan. Established in 1889 as Kalamazoo's first hospital, it has recently completed its fourth major expansion of facilities. The hospital has newly established centers for the diagnosis, prevention and treatment of cancer, heart and kidney diseases, and also offers a community mental health center and 14 other clinic operations.

Michigan Medicine's all-Borgess section

The scientific section of this month's *Michigan Medicine* is a special one. All of the articles are written by physicians on the staff of Borgess Hospital, Kalamazoo.

This unusual circumstance came about when, approximately eighteen months ago, Roland R. Springgate, MD, then Director of Medical Education, suggested an all-Borgess issue. As he explained, "the facilities, both care and educational, at Borgess Hospital have rapidly expanded over the past three years. We are in need of a vehicle to encourage publications from our 'old' and 'newly-acquired' staff and would like to accept the responsibility of the scientific portion of one issue of *Michigan Medicine.*"

Not long ago, the Borgess articles arrived at MSMS headquarters. They were read and approved by Scientific Editor John W. Moses, MD, and will fill both this and the September issues. The four in this issue center on the kidneys, while those in the following issue will deal with a variety of medical problems.

We hope our readers enjoy the articles. We would like to suggest that if other hospitals around Michigan like the idea and would enjoy filling an entire scientific section with staff contributions, they contact the managing editor.

The diabetic who has too much...

too much sugar, too much fat.

Maybe the last thing she needs is more of her own insulin. Especially when you consider that many overweight diabetics already have normal or high levels of endogenous insulin and that insulin is lipogenic.

If she just won't diet and oral therapy is indicated in adult-onset, nonketotic diabetes...

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lowers blood sugar without raising blood insulin.

For complete details, including dosage, please read the prescribing information. It's summarized below.

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apsules of 50 and 100 mg.

ndications: Stable adult diabetes mellitus; sulfonyl-
rea failures, primary and secondary; adjunct to
nsulin therapy of unstable diabetes mellitus.
ontraindications: Diabetes mellitus that can be
egulated by diet alone; juvenile diabetes mellitus
hat is uncomplicated and well regulated on in-
ulin; acute complications of diabetes mellitus
metabolic acidosis, coma, infection, gangrene);
luring or immediately after surgery where insulin
s indispensable; severe hepatic disease; renal dis-
ase with uremia; cardiovascular collapse (shock);
fter disease states associated with hypoxemia
Varnings: Use during pregnancy is to be avoided.
recautions: 1. *Starvation Ketosis:* This must be
ifferentiated from "insulin lack" ketosis and is
haracterized by ketonuria which, in spite of relatively normal blood and urine sugar, may result from excessive phenformin therapy, excessive insulin reduction, or insufficient carbohydrate intake. Adjust insulin dosage, lower phenformin dosage, or supply carbohydrates to alleviate this state. **Do not give insulin without first checking blood and urine sugar.**
2. *Lactic Acidosis:* This drug is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, periodic determinations of ketones in the blood and urine should be made in diabetics previously stabilized on phenformin, or phenformin and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH, and the lactate-pyruvate ratio. The drug should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis.

3. *Hypoglycemia:* Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.
Adverse Reactions: Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake. (B) 98-146-103-E (6/72)

For complete details, including dosage, please see full prescribing information.

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Opinion & Dialogue

"Prescription drugs – who should determine the maker?"

Dispenser of Medicine

Clifton J. Latiolais
President
American Pharmaceutical Association

"Too many doctors are indiffe
ent to the economic consequences
their decisions." So stated a recent
issue of *Medical News Report* (December 4, 1972), an independent
weekly newsletter published by forr
AMA Chief Executive F. J. L. Blasin
game, M.D.

Doctor, are you indifferent . . . ?

In discussing an anticipated i
crease in Blue Shield rates, Dr. Bla
ingame's newsletter had this to say

"In general, it can be said, MI
have given the impression they are
not particularly concerned with the
increase in cost of health care to th
patients . . .

"True, an MD's training is pri
marily scientific, but in the real wo
of practice, all of his scientific dec
sions have a price tag, or an econo
impact. The economics of health c
beckon the practitioner's attention
Concern for economics of medicin

Maker of Medicine

C. Joseph Stetler
President
Pharmaceutical Manufacturers Association

When the pharmacist recom-
mends that a drug product other th
the one ordered be dispensed, the
prescriber invariably permits the
change when he feels the best inte
ests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is nec
sary for the prescriber to know tha
the change is being contemplated,
and to be in a position to consent o
demur. Without that opportunity, t
unilateral decision of the pharmac
made in the absence of clinical kn
edge of the patient, could expose h
to needless risks, and in addition,
jeopardize the relationship betwee
the professions of Pharmacy and
Medicine. In my view, there is noth
in the pro-substitution argument th
offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim
that the primary justification for
changing the rules is the desire to
better utilize pharmacists' knowle
about drugs. Yet the pharmacist's
task to keep current on the entire
field of drug therapy, to some degr
puts him at a disadvantage. Most
often, a practicing physician will n
expert knowledge of no more than

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should be an obligation of medical practice...

"Medical societies ought to conduct continuing campaigns to point out the substantial savings that could be realized thru deductible insurance and protection for catastrophic illness. At the very least, they should, in the patients' interest, question the tactics of any insurance organization that raises health care costs by forcng policyholders to buy insurance they may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of their decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's nonsense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed o their patients for support in the ight against government interference with the private practice of medicine. And the public in the past has responded. It's time the American Medcal Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

Cost of Drugs

Insurance rates and hospital charges are only two factors in health care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists *are concerned*. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

---

r 30 drugs that he selects to treat the majority of conditions encountered in his practice. Moreover, the physiian's choice of a specific brand is based on his knowledge of the paent's medical history and current ondition, and his experiences with he particular manufacturer's roduct.

Some substitution proponents ave argued that the dispensing of a rescription is a simple two-party ransaction between the pharmacist nd the patient, and that a substituting pharmacist may avoid even a echnical breach of contract by simply otifying the patient that he is making he substitution. I would judge that ew courts would be sympathetic oward a pharmacist who substituted ithout physician approval and who ndertook a legal defense that seeks make the patient responsible for he pharmacist's actions.

educed Prescription Prices?

Substitution advocates are uggesting to the consumer, and parcularly the consumer activist, that educed prescription prices could llow legalization of substitution. e have seen absolutely no evidence justify this claim. To the contrary, xperience in Alberta, Canada, where ubstitution is authorized, suggests the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advocates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

Pharmaceutical
Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

108th MSMS Annual Session

Wednesday, Oct. 10, 1973

9-10:15 am	11-noon	12-2 pm lunch hour	2-3:15 pm	4-5 pm	cocktail hour	dinner hour	evening program
Internal Medicine	Internal Medicine	Allergy	Allergy	American Medical Writers	American Medical Writers	American Medical Writers	American Medical Writers
		Dermatology	Dermatology	Proctology	Gastroenterology	Gastroenterology	Gastroenterology
		Plastic Surgery	Plastic Surgery	Plastic Surgery	Orthopedic Surgery	Orthopedic Surgery	Orthopedic Surgery
		Occupational Medicine	Occupational Medicine				
			Otolaryngology	Otolaryngology	Otolaryngology		
			Ob.-Gyn.	Ob.-Gyn.	Ob.-Gyn.	Ob.-Gyn.	Ob.-Gyn.
			Pediatrics	Pediatrics	Pediatrics	Pediatrics	Pediatrics
			Ophthalmology	Ophthalmology			
			Urology				
			Physical Medicine				
			Clinical Pharmacology & Therapeutics				

Thursday, Oct. 11, 1973

9-10:15 am	11-noon	12-2 pm	2-3:15 pm	4-5 pm	cocktail hour	dinner hour	evening program
	Thoracic Surgery	Thoracic Surgery	Chest Physicians	Chest Physicians	Chest Physicians & Thoracic Surgery	Chest Physicians & Thoracic Surgery	
Pathology	Pathology	Pathology	Pathology	Pathology	Radiology	Radiology	Radiology
Surgery	Surgery		Surgery	Surgery	Psychiatry	Psychiatry	Psychiatry
Family Practice	Family Practice		Family Practice	Family Practice			
Acupuncture	Acupuncture	Emergency Physicians	Emergency Physicians	Neurological Surgery	Neurological Surgery	Neurological Surgery	
Public Health Preventive Medicine	Public Health Preventive Medicine						

MSMS announces 1973 Annual Session program plans

Michigan physicians who make the journey to Detroit Oct. 10-11 for the 1973 MSMS Scientific Sessions will find a thought-provoking and enriching series of medical programs planned for them.

Throughout the two days, meeting rooms in the Sheraton-Cadillac Hotel will be buzzing with discussions, question and answer sessions, slide and other visual presentations about the latest developments in carefully selected medical fields.

Each presentation this year is planned by the appropriate specialty society with its own members in mind, and with the best in speakers from Michigan and other states scheduled to keep their colleagues up to date.

Out of state speakers will come from Birmingham, Ala.; Charleston, S.C.; Columbus, Ohio; Durham, N.C.; New Brunswick, N.J.; New Orleans; New York City; Philadelphia; Providence, R.I.; Rochester, Minn., and Washington, D.C.

Topics will include stroke, acupuncture, emergency medical services, problems of confidentiality, "pain in the neck," thyroid diseases in children, diseases of the liver, the dizzy patient, the status of drug abuse rehabilitation in Michigan, surviving an auto crash, pap smears, gall stones, the new medical science—health care delivery, the "regulatory game plans"—including PSRO, QAP, KJASP and other "abbreviated aids to the physician"; fiberoptic colonoscopy and polypectomy, "The use and abuse of rhetoric as depressant, stimulant and placebo"; OB beds in Michigan, role of the family physician in the health care delivery system and rhetinoic acid.

OFFICIAL CALL

The Michigan State Medical Society will convene in Annual Session in Detroit, Michigan, October 7-11, 1973. The provisions of the Constitution and Bylaws and the Official Program will govern the deliberations.

John J. Coury, Jr., MD
President

Robert M. Leitch, MD
Council Chairman

Vernon V. Bass, MD,
Speaker

James D. Fryfogle, MD
Vice speaker

Attest:
Kenneth H. Johnson, MD, Secretary

Medical writers plan varied program Oct. 11 in Detroit

Egyptian mummies, art collections, and medical writing will be the topics of the meeting Oct. 11 during the MSMS Scientific Session being arranged by the Michigan Chapter, American Medical Writers Association, and the MSMS Ad Hoc Commmittee on Art Presentations.

From 5 to 6 p.m. in the East and West Rooms, the chapter will present a slide presentation, "An Autopsy on an Egyptian Mummy." The same program will be presented during the day on video tape in the Exhibit Hall, conducted by Thomas A. Cockburn, MD, Detroit, member of the Mayor's Committee for Human Resources Development.

From 4 to 5 p.m. in the East and West Rooms, Irving F. Burton, MD, Detroit, will make a presentation, also accompanied by slides, on "Art Collecting for Fun and *Not* Profit." Doctor and Mrs. Burton have amassed one of the country's most valuable art collections.

Running concurrently with the above programs, the Michigan Chapter also will present a workshop on writing for medical journals, from 4 to 5:30 p.m. in the Michigan Room, conducted by Guy Whitehead, PhD, Rochester, Minn., consultant in publication, Department of Biomedical Communications, Mayo Foundation. During the workshop, Doctor Whitehead will edit a scientific paper.

Doctor Whitehead will return following the chapter's dinner to present a second session at 8 p.m. in the Washington Room entitled "Personality in Medical Writing."

Pre-registration is required for the workshop by Sept. 26 and is limited to 50 participants. The registration fee of $15 includes the reception and dinner. Those interested should contact Harry Saltzstein, MD, President, Michigan Chapter, AMWA, Sinai Hospital Office of Bulletin Committee, 6767 W. Outer Drive, Detroit.

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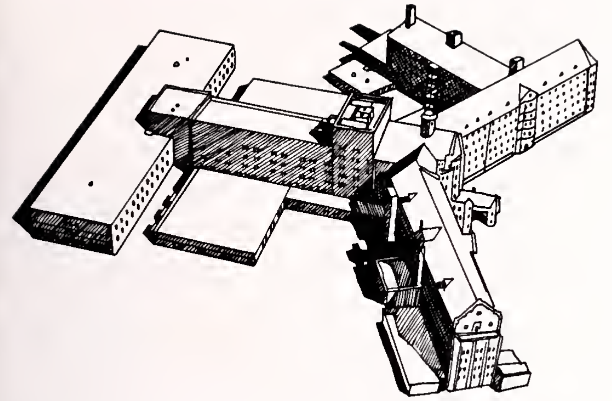

Borgess Hospital, Kalamazoo

Treatment of the female metastatic hypernephroma

By William G. Tucker, MD
Kalamazoo

Summary

A 52-year-old white female was first seen on July 17, 1970, complaining of hemoptysis, shortness of breath and chest pain. On June 2, 1970, the patient had undergone a right nephrectomy. At the time she was seen in July of 1970, she had several large cannon ball nodules in both lung fields which were not seen on preoperative chest films. During her evaluation, the only site of tumor which was located was within the lung fields and the patient was started on medroxyprogesterone acetate at 200 mgs., two times a week, deep IM. The initial review of the patient at six weeks showed an increase in size and number of the tumor masses in her lungs; however, subjectively, she had improved. There was no further hemoptysis and the pain had markedly decreased. At the three month evaluation, the masses had decreased in size and number and by six months, there was no evidence of disease within the lungs. The importance of continuing the medroxyprogesterone acetate in the face of early increasing disease is illustrated.

Renal cell carcinoma is responsible for more than 5,000 deaths per year[1]; approximately one third of the deaths are females. In the series reported by Talley, et al.[2] and Bloom, et al.[3] and other scattered reports, there were very rare regressions of metastatic renal cell carcinomas in the female. It has been the consensus of opinion that progestational agents used in renal cell carcinomas were of value for the male patient with metastatic renal cell carcinoma; however, physicians have been hesitant to use the progestational agent when faced with this problem in a female.

Case Report:

The following case summary illustrates the problem so often encountered with increasing disease at the first evaluation at the six week level and the three month evaluation period demonstrates the reason for continuing the medroxyprogesterone acetate.

Mrs. V.C. was admitted to Borgess Hospital, Urology Service, on May 31, 1970 complaining of hematuria. She had a palpable mass in the right flank and pyelograms revealed a tumor deformity of the right kidney. This had previously been evaluated in February of 1970 because of hematuria and at that time the IVP and retrograde studies were interpreted as normal and with the retrospectroscope, still one felt they were normal. The routine blood count was within normal limits. The urinalysis was essentially normal except for an occasional white cell. Renal function tests were normal. The serum creatinine was 0.9 mg%. Urine culture revealed no significant growth. The Profile 12 was normal. The chest x-ray showed a non-

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Doctor Tucker is director, Midwest Oncology Center, Borgess Hospital, Kalamazoo.

Scientific articles

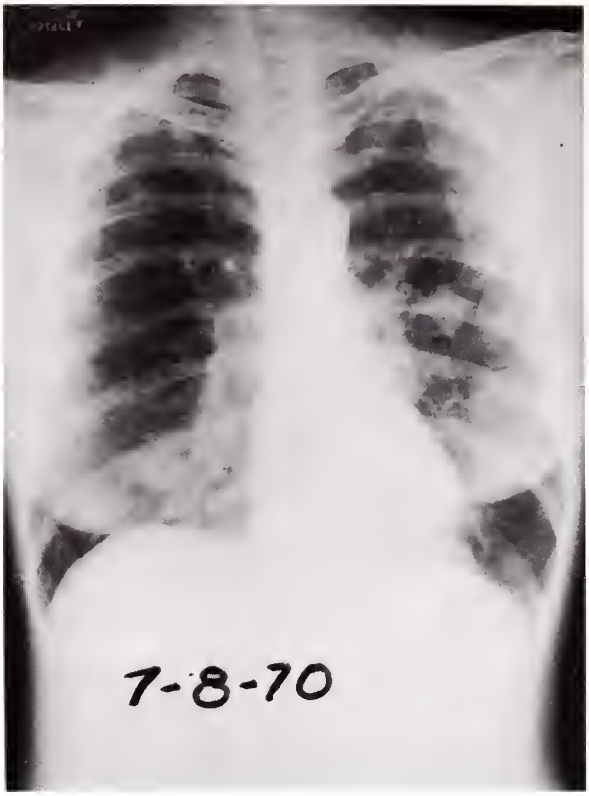

Fig. 1-A. Pretreatment

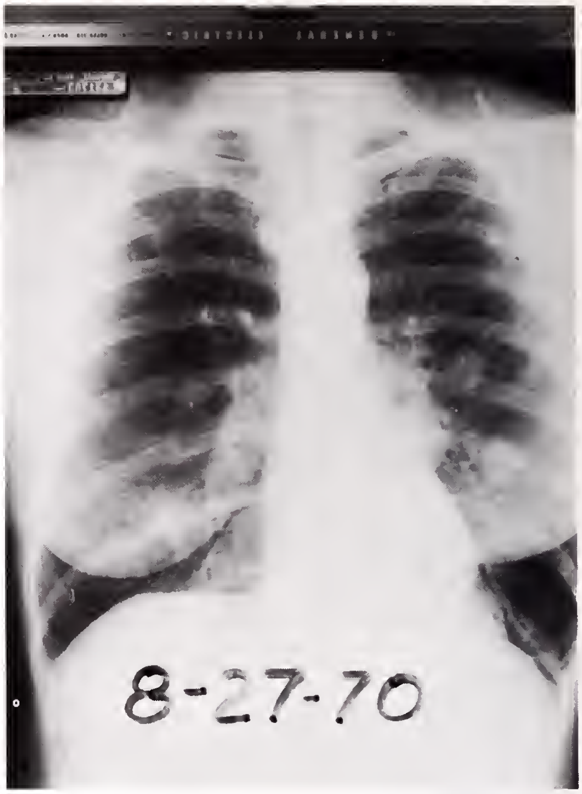

Fig. 1-B. Six-week interval after starting medroxyprogesterone acetate showing increase in size and number of tumor masses.

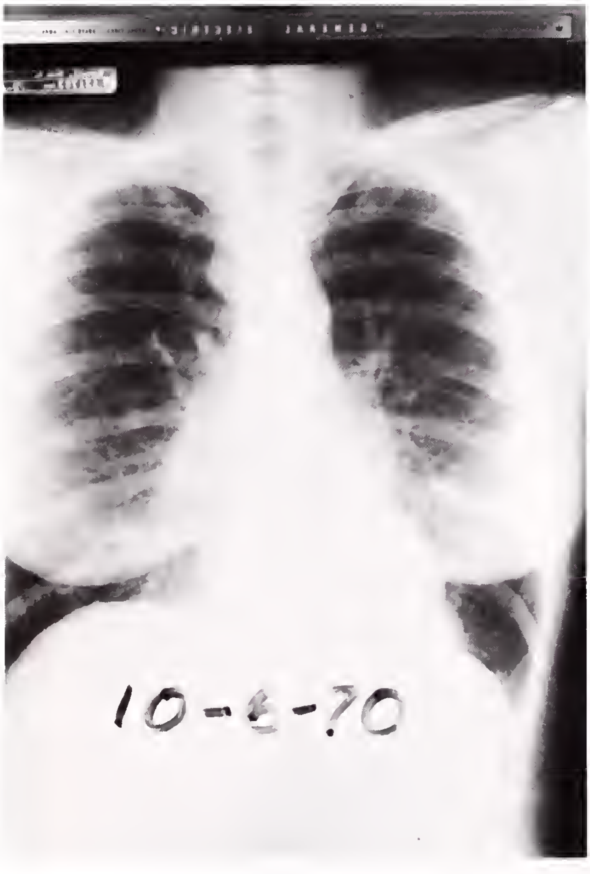

Fig. 1-C. Twelve week evaluation film after the start of medroxyprogesterone acetate showing decrease in size of tumor masses in number.

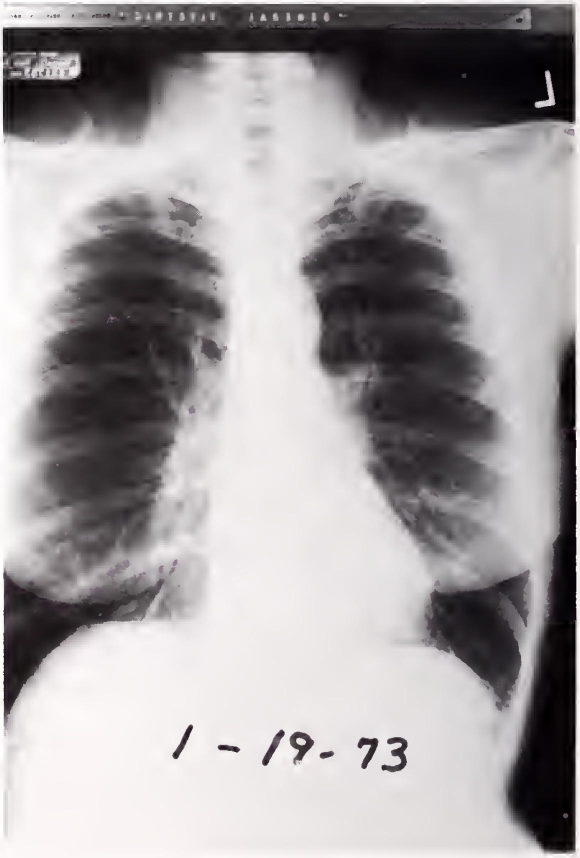

Fig. 1-D. Chest x-ray taken thirty months from the onset of medroxyprogesterone acetate showing the continued clear lung field since January of 1971.

calcified nodular density in the right lower lobe. On comparison to the chest film taken in February of 1970, it was felt that this was a similar lesion; however, technique was different in the two films and comparison was not totally possible.

On June 3, 1970, a transabdominal right nephrectomy was done. The kidney was grossly enlarged. The tumor was located on the posterior aspect of the kidney and growing outward posteriorly and this undoubtedly accounted for the lack of distortion on the pyelograms of February. The renal vein was thickened and felt grossly to contain tumor and, indeed, microscopically, it did contain tumor and thrombosis. The surgeon felt that the vena cava was not involved and that he was able to remove the kidney and tumor in total. The patient had a normal postoperative course and was discharged on the eighth postoperative day to be followed in the office in one month's time and a chest x-ray was to be followed at that time.

The chest x-ray was taken in July just prior to the return visit and there were multiple nodules in the lung. At this time, she had developed hemoptysis with a considerable amount of chest pain and some associated shortness of breath.

She was referred to the Midwest Oncology Center on July 17, 1970. At this time, she had right flank fullness, but a definite tumor mass was not palpable in this area and it was felt that this was mainly postoperative induration. Her symptoms in the week prior to being seen had increased to include anorexia and some mild degree of nausea. Her physical examination was significant only in that there were diffuse coarse rales throughout the lungs and the patient several times during the examination demonstrated the hemoptysis for which she was being seen. Her laboratory and x-ray workup did not reveal additional metastatic disease and, therefore, the patient was started on medroxyprogesterone acetate at 200 mgs. twice a week, deep IM.

The patient was next seen on August 27, 1970. Her appetite had improved slightly. Only occasionally over the past 10 days had she had a cough which was productive of a bloody sputum. On physical examination, there was a marked decrease in the number of rales which were heard in the chest and the right flank fullness had decreased quite markedly and the patient was considered to be clinically well. However, the chest x-ray taken at this time showed an increase in the size of the tumor masses.

The patient was next seen on October 7, 1970. She was asymptomatic. She had gained 20 pounds, but she also had stopped smoking as of June 1970. the only physical findings was a slight increased resistance in the right flank area and the chest x-ray at this time showed a definite decrease in the size of the tumor masses.

The patient has been seen on a six week interval since that time and in January of 1971, the lesions as reported by the radiologist show no definite residual of the metastatic nodular disease in the lungs and the chest x-ray has continued to remain clear as illustrated by the AP film of January 19, 1973.

The one problem that the patient has encountered with the medroxyprogesterone acetate is that her initial weight when first seen on July 17, 1970 was 108 pounds. In January of 1971, she was up to 152 pounds and remained at this range for the next five months at which time she started to control her diet remaining then at about 140 pounds until December of 1971, at which time, she started to go on a diet and by April of 1972, she was down to her normal weight of 120 pounds. She is completely active. As a matter of fact, she is actively engaged in breaking and training horses.

Discussion

Hypernephroma is a very predictable form of metastatic cancer. Everson and Cole[4] reported 176 cases of spontaneous regression of cancer. Of these, 31 were hypernephroma and nine of the 31 occurred in women. In fact of these 31 patients, 28 had partial to complete regression of presumptive pulmonary metastases. Twenty-one of the patients regressed following the nephrectomy, while five of the patients, the pulmonary metastases first appeared following removal of the primary tumor by radical nephrectomy and later spontaneously regressed. Woodruff, et al.[5] states that females do not obtain spontaneous regressions in renal cell carcinoma but almost exclusively, men do.

The fact that spontaneous regressions of hypernephroma are almost invariably associated with removal of the primary tumor has led the oncologists and the urologists to push for removal of the primary site of tumor. Hellstrom, et al.[6] demonstrated that sera from six tumor patients tested, one with melanoma, one with colonic carcinoma and four with breast carcinoma, who had become clinically tumor free could unblock (abrogate) the blocking effect of sera from patients bearing tumors of the respective types thus making it possible for immune lymphocytes to kill cultivated neoplastic cells in the combined presence of the unblocking and blocking sera. This would indicate that by reducing the quantity of tumor cells that a patient would again develop their ability to destroy smaller quantities of tumor cells. Also, Bentwich, et al.[7] theorized that many, perhaps all, tumor specific antigens may not in fact represent bona fide new molecular entities, but may be normally occurring antigens expressed in very different quantities to displaced ontogenically, architecturally, and perhaps even phylogenetically. The antigens found in association with neoplastic states were very similar to those of normal tissues in early life.

Vanamee, et al.[8] has shown the effectiveness of a fraction of bovine growth hormone to be effective in the prevention of stress ulcers in animals as well as being suggestively effective in humans for those patients who have previously had hypophysectomies. It is suggested that the growth of the mucosa is enhanced by this fraction of the bovine growth hormone. Certainly in males, we have been able to document regressions of hypernephroma with medroxyprogesterone acetate in greater numbers than could be anticipated by spontaneous regressions and with the patient presented in this paper, it is highly improbable that a spontaneous regression occurred and most likely that medroxyprogesterone acetate played an important role in reducing the size of the tumor initially. Cornette, et al.[9] has shown that medroxyprogesterone acetate given at 150 mgs., deep IM reaches a peak of 27 nanograms per cc on the fifth day post treatment and shows a gradual decline to 8 nanograms by the 24th day and then a slower decline to 5 nanograms by the 90th day and at 140 days, is at 3 nanograms per cc. Therefore, by administering 200 mgs. two times a week, there would be a gradual increase in the nanograms per cc found as long as this dose level would be continued. This could well account for the increase in tumor size during the first six weeks, as the required dose level had not been reached. The tumor destruction by medroxyprogesterone initially was not as rapid as the rate of growth of tumor cells and as the rate of destruction of tumor cells increased with the increasing dose level of medroxyprogesterone acetate, the immunological mechanism of the body was improved supporting a synergistic action of hormone and immunological attack on the tumor, or perhaps a third factor could be involved now that we have some evidence that fractions of the growth hormone are responsible for regeneration of certain tissues and the medroxyprogesterone acetate could be a blocker of the growth hormone fraction.

The patient discussed, although having a long disease free interval, demonstrates the importance of continuing medroxyprogesterone acetate therapy in the face of increasing disease at the six week evaluation time.

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Mass lesions of the kidney —modern diagnosis

By H. Dale Alkema, MD
Leonard A. Brunette, MD
William J. Butler, MD
N. Warn Courtney, MD
J. Alexander Gardner, MD
Richard McConnell, MD
Kalamazoo

Renal mass lesions become more frequent with age, occurring predominantly in persons past the fifth decade of life.[1] With increasing utilization of the excretory pyelogram as a basic screening prodecure for hypertension and a variety of other clinical disorders, asymptomatic renal masses are being more frequently discovered, and the predominant frequency of benign cysts as compared with renal malignancies is becoming more evident. Once considered a rare lesion, renal cysts have more recently been reported to occur as much as 20 times as frequently as renal malignancies.[2] While simple uncomplicated renal cysts probably require no therapy in the vast majority of cases,[3] renal cancer remains a lethal lesion. Surgical exploration has commonly been performed to differentiate the two. Yet, there remains a significant morbidity and mortality from this procedure,[2] particularly in the elderly patient in whom their incidence is greatest, and even surgical exploration has not been infallible.[4] How, then, in the present era, should one approach the patient with a mass in the kidney?

At Borgess Hospital the urologic and radiologic departments currently follow a diagnostic plan utilizing combinations of the following elements: (1) clinical evaluation of the patient, (2) visualization of the renal outline and collecting system by high dose excretory or retrograde pyelography, (3) selective renal arteriography (or in occasional instances infusion nephrotomography), (4) percutaneous needle puncture of the lesion under image intensification fluoroscopy, with aspiration and cytological study of fluid content, and radiographic visualization with injection of contrast material, and (5) surgical exploration in appropriate instances.

Clinical evaluation of the patient will never be entirely replaced by sophisticated radiographic procedures in urologic diagnosis. Weight loss, anemia, fever, flank pain or tenderness, leukocytosis, elevated erythrocyte sedimentation rate, and hematuria not otherwise explained, all may have an important bearing upon the clinical management of a renal mass of unknown character in a specific individual.

Radiographic visualization of the renal collecting systems, either by excretory pyelography, if adequate, or by retrograde technique has long been known to be unreliable in the distinction between benign and malignant renal masses.[5] Moreover, a renal lesion may be present without any visible distortion of the renal collecting system or renal contour. On the other hand, tumors originating in the transitional epithelium of the renal collecting system are usually visualized to greatest advantage by pyelographic techniques.

Consequently, following discovery of a mass in the kidney, further measures are usually required in order to achieve the specific diagnosis with acceptable accuracy. The percutaneous selective renal arteriogram, introduced by Seldinger in 1953,[6] permits precise visualization of the vascular pattern of the kidney, with an acceptably low rate of complications when performed in properly selected patients by technically competent personnel.[7] By this means, assuming that the examination is complete and of good technical quality, the accuracy in terms of alerting the clinician to the presence of malignancy is probably in the range of 95%.[8] Coversely, when the examination shows the findings consistent with renal malignancy **(Fig. 1)**, the surgeon may with confidence proceed with en bloc radical nephrectomy without the need of exposing the tumor for preliminary biopsy, an operative approach which has been shown to lead to significant improvement in long term patient survival.[9] However, certain categories of patients, notably severe diabetics, patients with extensive arteriosclerosis, and those with chronic low output cardiac failure, are more prone to complications

Borgess Hospital, Kalamazoo

The authors are with the Department of Radiology and the Comprehensive Renal Care Unit at Borgess Hospital.

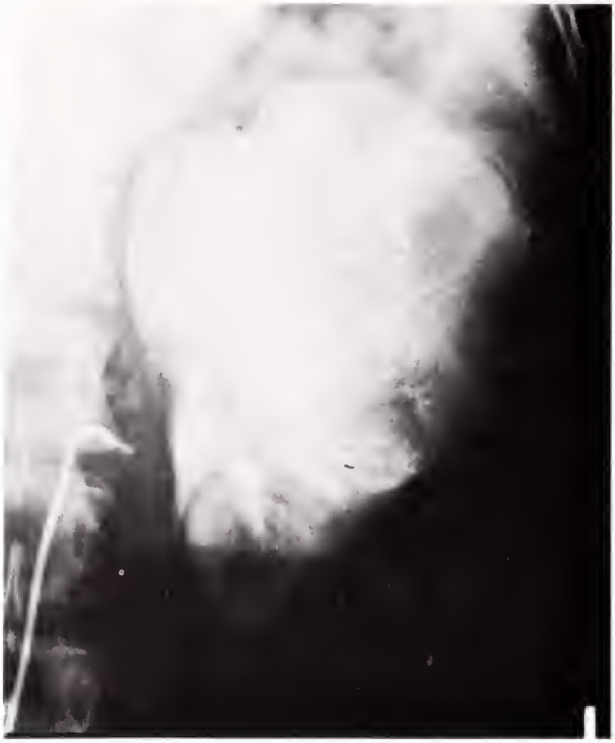

Figure 1: Large hypernephroma demonstrated by selective renal arteriogram. Pyelographic distortion was minimal.

following selective renal arteriography. Unfortunately, these patients, often elderly, are also at once beset with the greatest incidence of renal mass lesions and with the highest morbidity and mortality following surgical exploration of the kidney. A suitable compromise, when selective arteriography is contraindicated, may be the use of the intravenous infusion nephrotomogram, which usually permits sharper definition of the structural details of the lesion than does routine pyelography, although not permitting visualization of the renal vasculature. Some proponents of this examination have claimed a diagnostic accuracy approaching that reported for the selective renal arteriogram[4] and, indeed, have relied upon it as definitive in many instances without further confirmation, although our own experience, and that of other,[10] has been at variance with this.

In a small percentage of cases the selective renal arteriogram and/or the nephrotomogram will be falsely negative—i.e., will not alert the clinician to the malignancy which is present. This group probably constitutes less than 5% of cases studied, still unacceptably high in view of the lethal consequences of overlooking renal cancer. These cases are usually either solid tumors lacking the increased vascularity of most renal malignancies, **(Fig. 2)**, or are tumors which have undergone necrosis. To detect lesions of this category, percutaneous needle puncture of the lesion with aspiration of its fluid content, if any, for cytological study, and radiographic demonstration of its contour by injection of contrast material is carried out, **(Fig. 3)**. This examination, conducted under fluoroscopic control following visualization of the renal collecting system by pyelography or arteriography, is done with a small caliber obturator needle, with a high degree of accuracy, and in our hands as well as others[11] has been relatively free of complications. When conducted as a separate examination, it is often done on an outpatient basis. In many instances, following selective renal arteriography which reveals findings compatible with benign renal cyst, the patient is immediately turned to the prone position and percutaneous needle aspiration done, utilizing the still visible contrast material for localization. In such instances the patient will be observed in the hospital overnight, as is customary following arteriography.

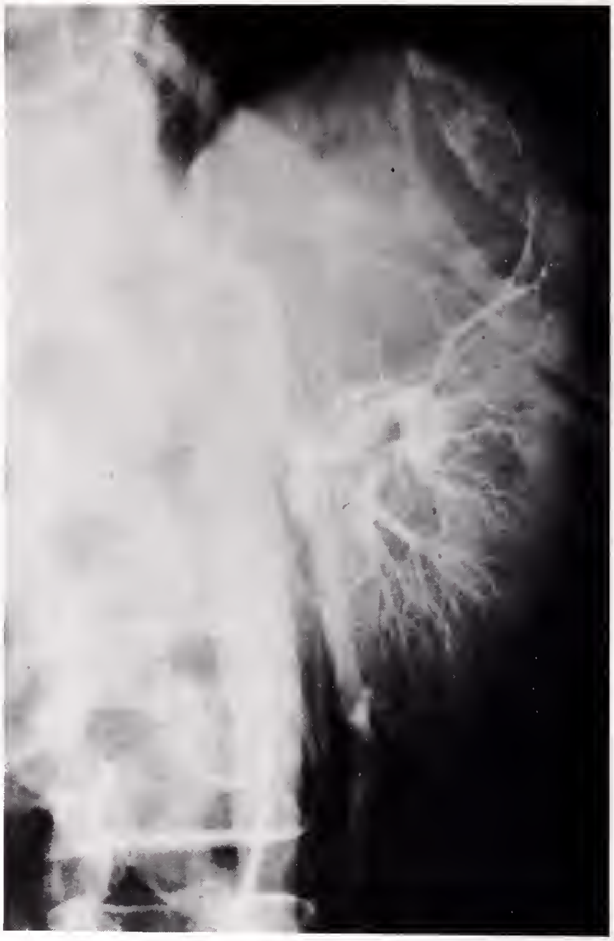

Figure 2: Falsely-negative arteriogram. Large avascular mass proven to be hypernephroma by needle aspiration and subsequent nephrectomy.

While definitely a theoretical possibility, to our knowledge no case has yet been discovered in which there has been recurrence of a renal malignancy along the needle tract following attempted needle aspiration. Of concern is our own observation at nephrectomy of minor but definite bleeding outside

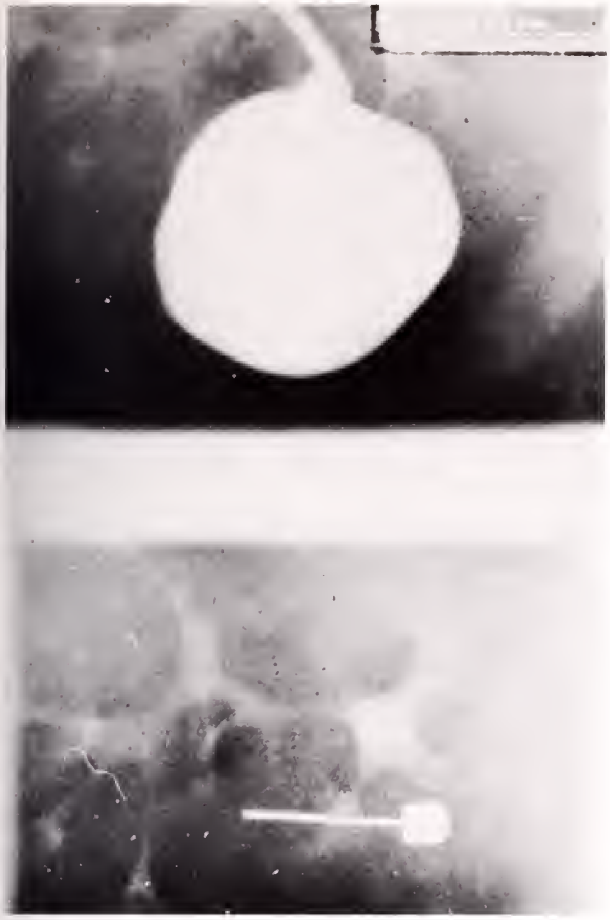

Figure 3: Benign renal cyst demonstrated by needle aspiration technique.

the perirenal fascia shortly following the aspiration procedure (in which the lack of fluid indicated a solid tumor), as well as published cases of tumor recurrence along the tract of needle biopsy of prostatic carcinoma,[12] apparently suggesting the possibility of a similar phenomenon about the kidney. Thus, this procedure, in our hands, is ordinarily limited to those cases in which the clinical criteria do not suggest malignancy and in which preliminary arteriography or nephrotomography is perfectly compatible with a diagnosis of benign renal cyst. Occasionally in elderly patients, if arteriography is contraindicated and operative risk high, needle aspiration might be attempted directly following pyelographic demonstration of a renal mass.

If, in a patient without clinical criteria of malignancy, selective renal arteriography reveals a pattern typical of benign cyst and needle aspiration reveals clear, cytologically negative fluid and a smooth-walled cavity free of any irregularity or filling defect, the diagnosis of benign cyst may be made with an accuracy very close to, but not including, 100%. The incidence of benign renal cyst and renal tumor occurring in the same kidney has been reported as varying from 2 to 7%.[1] Gibson has classified the various relationships in which these may occur.[13] A careful review of the isolated case reports through the years, however, reveals that in the majority of these instances of cyst and tumor together the diagnostic approach described above would have alerted the clinician to the proper conclusion, either by visualization of tumor vessels or by an irregular cyst wall or lack of a clear acellular fluid on aspiration. Yet, at least 5 cases have been reported in which clear cyst fluid was present within a smooth-walled cyst, whose walls contained no tumor indentation, but rather, thin sheets of malignant cells.[1,14] This exceedingly rare lesion probably represents a renal cyst developing distal to a parenchymal renal tumor which obstructs renal tubules and vasculature. The growth of the cyst exceeds that of the tumor itself, tending thereby to flatten and incorporate the tumor cells within its wall. All of the sophisticated radiographic procedures so far devised are defenseless against this rare biological phenomenon, and for that reason surgical exploration still remains available to the clinician in appropriate instances.

Summary

1. The current diagnostic approach to mass lesions of the kidney utilized at Borgess Hospital has been reviewed.
2. Diagnosis as to benign or malignant character of a specific renal mass can be made by nonoperative means with accuracy approaching, but not including, 100% of cases.
3. Surgical exploration of a renal mass for diagnosis may be reserved for those instances in which the operative risk is felt to be less than the relatively small, but documented, risk of overlooking renal cancer.

Experience at Borgess Hospital over the past four years with needle aspiration of selected renal masses in various combinations with the other studies described has amounted to approximately 80 cases. In only one case did a significant complication occur—that of septicemia following aspiration of a large mass which proved to be a renal abscess. Our experience relative to the accuracy of this diagnostic plan correlates well with that of others, reported above. The majority of lesions diagnosed as benign renal cysts, particularly in the elderly, have not been surgically explored, although this must still be considered in the younger, good surgical risk patient who presumably thereby has the least to lose and the most to gain.

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MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

MONTHLY SURVEILLANCE REPORT

CASES OF CERTAIN DISEASES
REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH
For the four-week period ending June 29, 1973

	1973 This 4-Week Period	1972 Same 4-Week Period	1973 Total To Above Date	1972 Total Same Date	Total Cases for 1972
Rubella	311	125	1,698	1,196	1,460
Congenital Rubella Syndrome	0	0	1	0	1
Measles	738	330	4,132	1,841	2,353
Whooping Cough	5	8	39	52	116
Diphtheria	0	0	0	1	1
Mumps	433	264	3,751	2,487	3,729
Scarlet Fever & Strep Sore Throat	1,343	649	13,127	7,278	13,304
Tetanus	0	0	0	1	2
Poliomyelitis (paralytic)	0	0	0	0	1
Hepatitis	257	271	1,951	2,245	4,322
Salmonellosis (other than S. typhi)	44	81	294	391	781
Typhoid Fever (S. typhi)	0	1	6	5	7
Shigellosis	48	53	285	269	574
Aseptic Meningitis	13	9	71	39	266
Encephalitis	20	6	84	39	108
Meningococcic Meningitis	6	2	32	29	55
H. Influenza Meningitis	14	8	66	42	81
Tuberculosis	110	136	716	906	1,609
Syphilis	367	365	2,274	2,536	4,815
Gonorrhea	2,129	1,845	13,804*	11,098	24,728

Information can be supplied by the local health department on the local incidence of disease.

*corrected total

Maurice Reizen, MD, Director
Michigan Department of Public Health

Ascorbic acid depletion in chronic hemodialysis patients

By Jean Burge, RD, MS
Hi Sung Park, MD
Kalamazoo

One of the major handicaps for the chronic hemodialysis patients is the restriction of food intake. Foods which are high in sodium and potassium are commonly restricted in order to prevent hypertension, congestive heart failure and hyperkalemia. Prior to dialysis many of these patients have been following conservative treatment programs of protein restriction for many months. Repletion of nitrogen and caloric stores and general improvement of nutritional condition can be accomplished during dialysis treatment. Relatively generous amounts of calories and protein as well as multivitamin supplementation are recommended for these individuals at most centers.

The fact that many water soluble vitamins are lost through the hemodialysis process has been well documented.[1,2] Not much attention, however, has been given to ascorbic acid. The few studies completed have shown depletion of ascorbic acid in hemodialysis patients as would be expected.[3,4] We, therefore, decided to determine the serum ascorbic acid levels of our hemodialysis patients.

Materials and Methods

Ten of the chronic hemodialysis patients from our unit were studied for plasma ascorbic acid levels. These patients are currently being dialyzed six hours daily, three times per week. The patients were both male and female and length of time on the dialysis programs varied from three to 15 months. Three different dialyzers were used during the periods studied. All patients were allowed 60 grams of protein, 60 mEq of sodium and 60 mEq potassium in their diet.

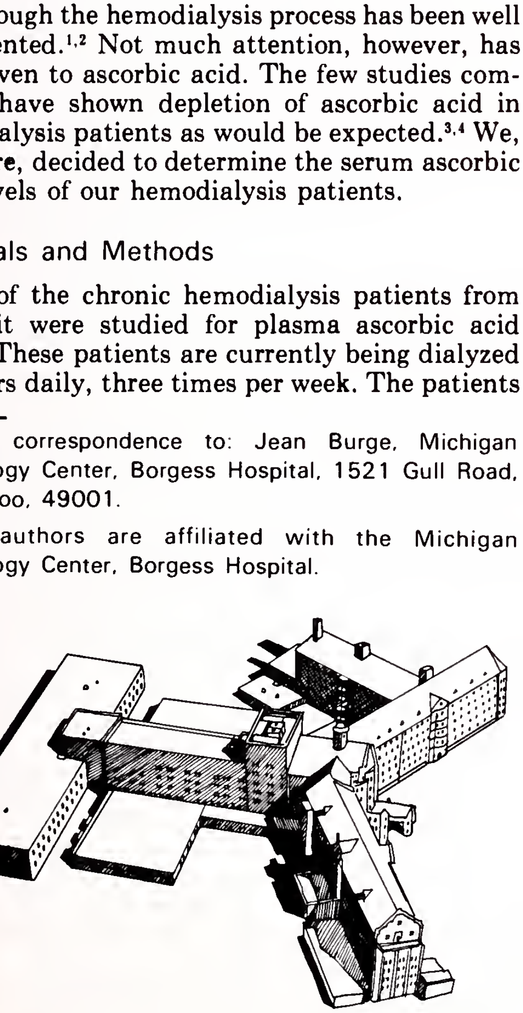

Table 1. **Plasma ascorbic acid levels[1] of patients undergoing maintenance hemodialysis.**

Pt.	Before Supplementation	After Supplementation
	mg%[2]	mg%[3]
C.C.	0.3	2.8
V.C.	0.5	2.1
L.D.	0.5	3.7
F.G.	<.1	2.9
G.H.	0.2	2.9
K.H.	0.5	3.6
R.M.	0.1	2.9
L.R.	1.8	1.8
F.S.	0.6	3.3
G.W.	1.1	2.9

1. All samples were analyzed by Bio-Science Laboratories, 7600 Tyrone Ave., Van Nuys, Calif. 91405
2. All data was collected on pre-dialysis arterial samples
3. Ascorbic acid in one 500 mg dose was given in P.M. after dialysis

Plasma ascorbic acid was determined on blood samples obtained prior to dialysis. These patients were then started on 500 mg of oral ascorbic acid daily at bedtime or after dialysis. Predialysis plasma ascorbic acid levels were repeated after two months on this program.

Results

In 7 of 10 patients the plasma ascorbic acid increased from below normal to normal levels **(Table 1).** One patient with a low level showed a significant increase in plasma ascorbic acid. In two patients the initial plasma ascorbic acid level was normal.

Discussion

Our studies indicate that multivitamin therapy alone is not sufficient to prevent an ascorbic acid deficiency in most hemodialysis patients. Foods such as fresh citrus fruits and vegetables which are good sources of ascorbic acid must be restricted because of potassium contents. The average hemodialysis patient consumes less than 40 mg ascorbic acid from his diet (60 mg is the

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Recommended Dietary Allowance for normal individuals).[4,5]

Severe ascorbic acid deficiencies produce scurvy. The pathological signs are almost entirely confined to the failure in maintenance of supportive tissues of mesenchymal origin, such as bone, dentine, cartilage and connective tissue.[6]

Ascorbic acid has also been associated with the release of free folate from folic acid conjugates in food,[7] and Nicol et al.,[8] have shown that ascorbic acid is involved in the metabolism of folic acid to its active form, citrovorum factor. Mazur[9] has reported that ascorbic acid and adenosine triphosphate are involved with the biochemical mechanism for the transfer of plasma-bound iron to the liver and its subsequent incorporation into ferritin. McCurdy and Dern[10] reported that ascorbic acid potentiates the absorption of iron from the intestinal tract. Plasma ascorbic acid level of 0.5 mg% or less is indicative of ascorbic acid deficiency.[6]

Symptoms normally associated with ascorbic acid deficiencies in hemodialyzed patients have been reported. Burge et al.,[4] observed abnormal bleeding in some hemodialysis patients which was diminished after treatment of 500-700 mg/day of ascorbic acid. It would be difficult to interpret the practical importance of low ascorbic acid levels in chronic dialysis patients. However, correction of the depleted plasma ascorbic acid by 500 mg of oral ascorbic acid once daily after dialysis is relatively easy. Based on the above studies and other reports we have developed a program for our dialysis patients which includes treatment with multivitamins once daily, folic acid 1 mg daily, ferrous sulfate 300 mg tid and ascorbic acid 500 mg daily.

We have noted symptomatic improvement in these patients' well being and some of these patients have markedly increased their hematocrit levels with the same dialysis program. It is our clinical experience that within a few months following adequate dialysis there is a tendency for the hematocrit value to increase.

All of these phenomena make it increasingly difficult to interpret the cause of improvement. It is reasonable that more adequate control of uremia by more adequate dialysis and maintaining optimal nutrition of the patient including administration of all water soluble vitamins and iron is important to the well-being of the long term hemodialysis patient.

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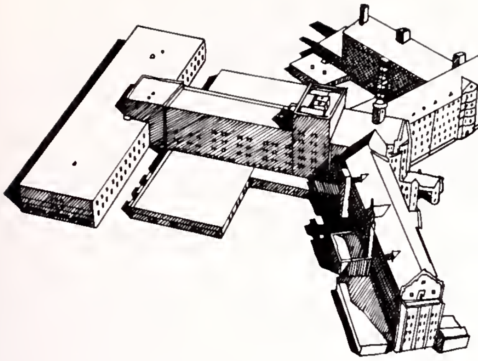

Comprehensive renal care in a community hospital

By William J. Butler, MD
Kalamazoo

The City of Kalamazoo is centered in the southwestern part of Michigan, with a surrounding population of approximately 1.5 million within an hours drive. Skilled services in the renal subspecialties other than urology have been concentrated in the eastern part of Michigan and the Chicago area, adding the additional hardship of travel to patients requiring these services from this area. Borgess Hospital in 1965 and 1966 found itself in a position to expand and develop programs in step with the rapidly changing political and medical climate in the health care fields. A coronary catheterization unit and an oncology unit were established utilizing a multi-disciplinary team approach in the care of patients, combining inpatient and outpatient care within the hospital utilizing the same personnel. It was within this climate that the present comprehensive renal care program developed.

The concept of providing a complete clinical and research service designed and staffed to diagnose and treat all catagories of renal disease has gradually evolved over the past three years, following early nebulous and groping attempts to improve urological patient care. A thorough study and evaluation of the urology service in the hospital, which recommended urgent expansion and upgrading of the nursing service, grouping the patients in one area, and reorienting the thrust of the effort so as to include the treatment of all renal diseases, was reported to the hospital administration and board of trustees in January, 1970.

This report stressed the concept that such a program would compliment expansion of programs in geriatrics, rehabilitation of neurologic disease, cardiovascular renal disease with hypertension, nephrology, endocrinology, oncology, diagnostic radiology and radio therapy. The volume of urology patients in the hospital has increased 400% from 1959 through 1969. A total of 1,844 intravenous pyelograms were obtained in 1962 in Kalamazoo compared to 3,867 in 1969. The average daily Borgess Hospital census of urology patients was 22 and it was decided a 32 bed floor could be assigned to the service and the extra beds could be filled with accommodations from other services. An exceptionally talented nursing supervisor, in conjunction with the nursing education department, rapidly organized an intensive orientation and education program for the newly recruited nursing staff. This required active participation of the attending urologists. A unit manager was appointed with an adequate budget available to meet the needs of the unit. A minor surgical room was constructed on the floor to permit cystoscopy, prostatic biopsy, and subsequently insertion of arteriovenous shunts for hemodialysis. This room also serves outpatients and is staffed and maintained by the floor nursing staff, thus expanding their comprehension and skills in all phases of urologic service.

The primary objective of the Comprehensive Renal Care Program is to improve patient care, with particular emphasis on the needs of the patient as a total being as opposed to the narrower view of his subspecialty disease. The nursing service in this hospital is decentralized, i.e., the assistant director of nurses over the comprehensive renal program reports directly to an administrator in charge of nursing affairs as do six other assistant directors. This permits more rapid decisions and close contact with the hospital administration. The duties of the Assistant Director of Nursing are to supervise nursing care, solve problems, develop programs with other hospital services as needs arise, recruit skilled and interested personnel, develop necessary educational programs, and in general provide administrative services. The unit manager maintains the unit physical plant and supplies, and submits yearly budget needs.

In order to explore and facilitate closer ties with other hospital services, a coordinating committee was organized and functions under supervision of the attending physicians. The committee is composed of the assistant director of nurses, the patient care coordinators, the director of occupational therapy, the director of physical therapy, and the renal social worker. A certain degree of decision making was delegated to the committee for the selection of patients for occupational and/or physical therapy while on the service. Occupational and physical therapy are not looked upon as passive programs. The therapist is present with the patient and provides emotional support and an outlet for vocalizing fears and concerns.

Doctor Butler is development coordinator of the Comprehensive Renal Care Unit at Borgess Hospital.

A weekly meeting of this committee facilitates communication and integration of their services to the patients. A continuing flow sheet is maintained of the impressions of each department and the floor nurses as to the patient's progress. Regular review by supervising physicians gives some evaluation as to the success or failure of the program. Thus far it has been very successful. We have found that these services improve the emotional status and provide exercise and rapid ambulation in the chronically ill or aged patient, shortening hospital time, and increasing the speed of rehabilitation. Transitions from gross physical therapy to occupational therapy and the use of the fine muscle movements have occurred more rapidly and with better timing in the chronically ill patients. This particular committee has proved useful in three important aspects. It develops closer and more efficient cooperation of hospital services. Secondly, it provides a stage for introduction of new services. Thirdly, it emphasizes concern for the total patient and encourages patient-oriented nursing versus task-oriented nursing.

The California Kidney Disease Planning Conference, December, 1970, gave added impetus and support in the direction that the renal care program was taking. At this point it was obvious that capabilities in renal transplantation would necessarily accompany further expansion of renal services as previously envisioned if ours was to be a complete and total service. It was felt that in order to responsibly serve the potential population base we should be prepared to provide at least 25 renal transplantations per year and to incorporate most of the renal subspecialty services discussed in the California report. Furthermore, the addition of these services should conform to the code for dialysis units and renal transplantation units being developed by the Michigan Public Health Department. Such an undertaking demands strong support of the hospital board and administration and a comprehensive, or a multi-discipline team approach. The additional services were then added in September, 1971, and easily fitted into the existing organization. Two nephrologists joined the staff in September, 1971, and this increased to three nephrologists at the end of 1972. The dialysis program which started with two beds in September, 1971, has been expanded to a seven-bed unit, including a three-bed limited care section. Along with the nephrologists came a skilled organization of dialysis nurses and technicians and in addition a basic research program with two qualified research biologists. A skilled renal dietician and an experienced and skilled social worker in the field of dialysis and chronic renal disease were added as full time personnel in the department. A renal outpatient clinic was established that is staffed by the same team that cares for hospitalized nephrology patients.

A renal transplantation team was established and at present is composed of two urologists, three general surgeons, three nephrologists, and consultative services in anesthesiology, diagnostic radiology, immunology, and the laboratory services. Twelve renal transplants were accomplished in the first year of the program's existence. The hospital laboratory through a grant from the Michigan Department of Public Health provides an accurate tissue typing facility using Terasaki's technique and a Terasaki trained technician.

At present a highly sophisticated program for diagnosis and management of hypertension is being established under the direction of a physician with a subspecialty in hypertension and clinical pharmacology. The hospital laboratory has cooperated fully and in the process developed a rapid method for detection of renin levels.

As further evidence of increased activity, 4,926 intravenous pyelograms were performed during 1972 in Kalamazoo. Selective renal arteriography increased from 136 in 1969 to 160 in 1972. A screening program for early detection of renal disease has been developed and implemented on the renal care service, oncology unit, and neurosurgical unit with plans for expansion to other services in the near future.

The objective of the comprehensive renal care program is to improve care by providing a program designed to meet the needs of the total patient. In an era of ever-increasing medical and technical subspecialization, comprehensive care is best delivered by a multi-disciplinary team which makes appropriate use of allied health personnel. Optimal use of the team approach requires an efficient organizational structure and open channels of communication. The multi-disciplinary team provides a way to care for the patient as a whole person, and allows the physicians to make the most effective and efficient use of his specialized skills.

The future of the program is bright and exciting. Additional cooperative ventures are envisioned with other hospital services such as stroke rehabilitation combining the renal care unit with the cardiology department and neurosurgery division. A newly established outpatient geriatric service could utilize some of the existing channels in the renal division for extending continuing education to the convalescent facilities in the area. A faculty combining nursing expertise in geriatric care from the various hospital divisions could easily be provided. Audio-visual educational aides are being produced for our own needs and can be offered to the surrounding health care facilities. In short, the potential for growth of integrated programs within the hospital and community seems unlimited.

Perinatal tips

The following case from the files of the Wayne County Medical Society Perinatal Mortality Study Committee is presented as an aid in continuing education.

By Paul M. Zavell, MD
Detroit

Maternal

This was the first pregnancy for this 24 year old, white, Gravida I, Para 0 (I) female. She was not seen until her fourth month of pregnancy but did have regular prenatal visits thereafter. Her last visit was at the eighth month of pregnancy, one month before the infant was born.

At her first prenatal visit she had the following lab findings: Serology was negative, Blood Type of O+ with Hemoglobin of 12.6 and Hematocrit of 39%. HAI test for Rubella was positive through titer of 1:20.

During pregnancy she gained 16½ pounds and her blood pressure varied from 140-145/80-85.

After only six hours, 47 minutes (1st stage 3' 30", 2nd stage 3' 14" and 3rd stage of 3") *total* labor she delivered a term, seven pound, one-half ounce white male infant by assisted breech with Piper's forceps. The obstetrician noted that the delivery was difficult with some tugging necessary. Her membranes had ruptured spontaneously 10 hours before labor began. Her post-partum course was uneventful.

Fetal

This seven pound, one-half ounce white male infant had considerable problem with initiation of breathing, needing suction of nasopharynx and emptying of gastric contents by lavage. At one minute he had an apgar score of 4-5 (cyanotic, limp, poor breathing). He was placed in an incubator for heat and oxygen. However, color and limpness did not improve.

A pediatrician was called at about one and a half hours of age, and 30 minutes later he arrived. He noted the infant was limp and cyanotic with heart rate of 132/minute but heart tones soft and distant. His initial impression was "newborn white male with hypoxia and hypothermia." He ordered only a chest x-ray (in addition to prior orders noted) that showed only "mild fetal atelectasis."

The infant was seen again about seven hours after birth when his condition failed to improve. The only therapy ordered was to "increase oxygen" in incubator. Six hours later the pediatrician again resaw the infant adding high mist to the oxygen being given the infant. Despite the additional help, the infant's condition steadily deteriorated with noticeable irregularity of heart beat and "distant heart tones of poor quality" and irregular respirations with increasing cyanosis.

The infant expired at 18 hours of age. An autopsy was obtained that showed massive hemorrhage of both adrenal glands.

Perinatal Committee Comments

1. Usually Piper's forceps are used to help guide the head in an assisted breech. It is rare to need "tugging." If such should be necessary, extreme care to avoid injury to the infant should be exercised. Hyperextension of the infant's body can result in cord injury with resulting C.N.S. problems. Obstetric pressure on the infant's back using the obstetrician's thumbs can lead to injury (kidneys, adrenals, etc.) of the infant.
2. Mothers in the last one to two months of pregnancy should be seen more often than one time per month. It is suggested either weekly or biweekly visits are more acceptable and more likely to pick up unexpected obstetrical (maternal and/or fetal) problems.
3. Testing for Rubella using the HAI test is best done using fresh blood samples. Unless there is known Rubella it is suggested that those with low titers should have repeat HAI tests done a few weeks or months later to help rule out unsuspected disease. However, this is not necessary if the mother has received Rubella immunization in the past.
4. With an infant having problems there is little excuse for waiting one and a half hours to call the pediatrician. Once this infant was seen, the Committee felt a more aggressive diagnostic approach was in order than the "wait and see" approach used here.
5. Hemorrhage somewhere should have been suggested here because the continued signs of shock persisted. Additional diagnoses could have been a cardiac problem (pericardial effusion or pericardial tamponade) and C.N.S. depression with hypoxia (severe) resulting in C.N.S. injury.

Doctor Zavell is chairman, Perinatal Mortality Study Committee, Wayne County Medical Society, and a member of the Neo-Natal and Hospital Care Committee, Michigan Chapter, American Academy of Physicians.

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Paul T. Lahti, M.D., Royal Oak	1973
John W. Moses, M.D., Detroit	1973
Robert E. Rice, M.D., Greenville	1973
Donald N. Sweeny, Jr., M.D., Detroit	1974
John J. Coury, M.D., Port Huron	1974
George W. Slagle, M.D., Battle Creek	1974
James C. Danforth, Jr., M.D., Grosse Pte. Woods	1974

Alternates

	Term Expires
Frank B. Walker, II, M.D., Grosse Pointe	1973
Donald T. Anderson, M.D., Kingsford	1973
Richard McMurray, M.D., Flint	1973
Brooker L. Masters, M.D., Fremont	1973
Marjorie Peebles Meyers, M.D., Detroit	1974
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If you're moving, Doctor, you have these responsibilities

When Michigan physicians close their practices in one area to move to another, they have responsibilities to their patients which are outlined by the MSMS General Counsel Lester P. Dodd, Detroit.

Mr. Dodd emphasizes there is no easy or completely safe formula, but he advises:

1. The physician send a letter to patients not under continuing care at least 30 days prior to closing so that those patients will know they must seek care elsewhere when needed;

2. Patients under continuing care be notified personally and in ample time for them to secure the services of another physician so that the present physician shall not be guilty of abandonment. Personal discussion followed by a letter to those patients is recommended.

3. With respect to patient records, the doctor should not hand over his records to the patient nor to another physician except with the patient's consent. The doctor should inform the patient by letter that his records will be preserved and will be made available to any other physician upon the patient's written request.

4. Legal counsel recommends that records be preserved for at least six and preferably 10 years and in the case of minors for at least two years after the patient would have reached 21 years of age.

5. The patients should be advised as to where their records will be kept.

MSMS endorses AMA's Michigan lecture series

MSMS officially has endorsed a series of seminars on 10 college and university campuses around Michigan which will be sponsored this fall by the AMA Council on Foods and Nutrition. The purpose of the program is to inform students and faculty of recent developments and to stimulate interest in the medical sciences.

The seminars will be held on the campuses of Albion, Aquinas and Calvin Colleges, Central Michigan University, Ferris State, Hillsdale, Hope, Kalamazoo and Lake Superior State colleges and Northern Michigan University.

County medical societies in the areas surrounding the schools also are being asked to lend their endorsement.

Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

William B. Barr, MD, 3500 N. Logan, Lansing 48914
Marko V. Belej, MD, 1101 Sigsbee St., Hancock 49930
Herbert M. Blair, MD, 638 Watersedge Court, Ann Arbor, 48105
Robert F. Bort, MD, 721 Peninsula Ct., Ann Arbor, 48105
Roy W. Boyer, MD, 815 N. Ohio Ave., Gaylord, 49735
Andrejs Dimants, MD, Box 307, R.R. #3, Three Rivers, 49093
Parviz Djariri, MD, 8209 Allen Road, Allen Park 48101
Walter L. Everett, MD, 3800 Woodward Ave., Detroit, 48201

"Give it to me straight, Doc. How much time do I have—seventy, eighty, ninety years. . . . ?"

Philip Goldhammer, MD, 3001 Miller Rd., Dearborn 48121
Edmond T. Gonzales, MD, Children's Hospital, Detroit, 48201
Lloyd B. Greig, MD, 2720 Golfside Rd., Ann Arbor, 48104
Mark W. Hinshaw, MD, 220 Cherry St., S.E., Grand Rapids, 49503
W. David Jacoby, MD, Henry Ford Hospital, Detroit, 48202
Ronald J. Jakubiak, MD, 214 Medical Arts Building, 1322 E. Michigan, Lansing, 48912
James W. Karolyi, MD, 15101 Southfield, Allen Park, 48101
Miroslav Kollar, MD, 6425 Huber, Detroit, 48211
Harry N. Kotsis, MD, 17751 E. Warren, Detroit, 48224
Clyde H. Kratochvil, MD, Upjohn Company, Kalamazoo, 49006
Dennis P. LeGolvan, MD, 2287 Manchester Rd., Ann Arbor, 48104
Paul Limadjaja, MD, P.O. Box 308, Moyer Diagnostic Clinic, P.C., Baraga, 49908
Jack I. Ludatscher, MD, 701 N. Logan #215, Lansing, 48915
James W. McCarthy, MD, 515 Lakeside Dr., S.E., Grand Rapids, 49506
Edna C.S. McInerney, MD, 1221 Ludington, Escanaba, 49829
J. Fletcher Murphy, MD, Department of Medicine, B-220 Life Sciences Bldg., Michigan State University, East Lansing, 48823
Gil F.S. Olegario, MD, Beyer Memorial Hospital, Ypsilanti, 48197
Juan Gonzales Posada, MD, 1414 Somerset, Grosse Pte. Park, 48230
K.L. Ramadas, MD, Box A, Ypsilanti, 48197
Hernando Rodriguez, MD, c/o Newberry State Hospital, Newberry, 49868
William G. Schetter, MD, 179 Higman Park, Benton Harbor, 49022
Paul T. Sheridan, MD, 200 Jefferson Ave., S.E., Grand Rapids, 49503
Douglas B. Siders, MD, 220 Riverview Dr., Ann Arbor, 48104
Albert W. Sparrow, MD, Dept. of Human Development, Michigan State University, East Lansing, 48823
George H. Steele, MD, 2225 Delaware Dr., Ann Arbor, 48103
William C. Trowbridge, MD, 1127 Esther Ct., Roscommon, 48635
Aliye Tugrul, MD, 551 Linn St., Allegan 49010
Lee C. Underwood, III, MD, 1219 Van Dusen, Ann Arbor 48103
Charles W. Webb, MD, 50 College Ave., S.E., Grand Rapids, 49503
Daniel A. Weller, MD, VA Hospital, Cincinnati, Ohio, 45219
Jawad Zamiri, MD, 3800 Woodward Ave., Detroit, 48201

Socio-economic

Beware the agent who undermines confidence in MSMS group insurance policies

By Ben P. Stratton
MSMS Insurance Agent

In the fall of 1972 a member of the Michigan State Medical Society was advised to make a decision that will cost him over $2,500 in unnecessary expense during the next 10 years.

A con game perhaps? No, the advice was given by a trusted insurance agent. The decision involved replacing the member's MSMS disability protection with an expensive individual policy with a cost nearly double that of the group protection.

Why would an intelligent physician allow himself to be talked out of a substantial sum of money?

The reason is quite simple. He was willing to listen to someone he trusted and the trusted agent could present a plausible sounding case based on incomplete comparisons, half-truths, and, sometimes, downright lies.

It is time to expose this type of agent who, usually for no reason other than his own gain, attempts to persuade physicians to drop their group protection so that replacement policies with high premiums, and incidentally high commissions, can be sold.

It may be true in some cases that an agent is conscientious in making such a recommendation. But in these casses, the agent hasn't taken the trouble to find out all the facts about the *MSMS disability plan* and therefore would appear to be less than competent.

What are the scare tactics most commonly used?

One stands out glaringly above all others. The member is told that he has no guarantee that his protection will be countinued if the master policy is cancelled or if he leaves the group. This is a false statement. The MSMS disability plan provides a conversion guarantee up to age 65.

Another tactic is the explanation that the individual policy is broader than the group. This, too, is false. The truth is that there is very little difference in the coverage assuming that the individual policy is high quality (and also high priced). Claims on both group and individual policies are usually handled exactly the same by company claims personnel.

How can you be sure you won't fall victim to bad advice even though given by a well-meaning agent?

There is a simple answer. Ask the agent to reduce his recommendation to writing and to explain in detail why you should pay a higher price for your disability protection than you are now paying.

The Insurance Bureau, Department of Commerce, State of Michigan, 111 N. Hosmer Street, Lansing, will help you make a decision. They may also question the tactics of the involved agent. The MSMS Department of Operations and Member Services is also ready and willing to offer its assistance in such cases, as are the insurance administrators, Ben P. Stratton Agency, Inc. of Lansing and Southfield.

In closing it should be noted that there are instances where additional protection is needed. The MSMS plan provides a maximum of $1,000 monthly indemnity.

In cases where higher amounts are desired, it is to the member's advantage to either procure other group coverage or to seek quality guaranteed renewable or non-cancellable income protection from reliable sources.

But beware of the agent who would undermine your confidence in the MSMS disability plan which has been in successful operation for 23 years.

Michigan MDs' patients eligible this fall for coordinated rehab benefits

By Judith Marr
Managing Editor

Beginning this fall, physicians will be advised that certain of their patients may be eligible for rehabilitative benefits under a new project.

That is when a new Rehabilitation Demonstration Project, endorsed in June by the MSMS Council, will go into effect for patients hospitalized in southern lower Michigan.

The project was negotiated by the United Auto Workers and auto management in 1970, and is to go into effect before the end of the current UAW contract. Endorsement was recommended to The Council by the MSMS Rehabilitation Committee, chaired by Stuart L. Cohn, MD.

The project will provide a study of rehab processes today. Its major goals are to determine rehab usage and to determine where there might be a lack of benefits implemented.

As explained by Joseph N. Schaeffer, MD, Detroit, committee member who has worked most closely with those initiating the program, the physician's role will be to recognize that his patients' rehabilitative care may be coordinated, if he wishes.

Michigan Blue Cross will initiate a notice to hospital coordinators of a patient's possible eligibility based on certain conditions.

In-hospital employes, often home care coordinators, then will notify the physician of the rehabilitative care benefits available to those patients.

The physician then will have the option to refer his patient to one of a half dozen rehabilitative facilities around the state. He will be free to accept or reject the offer of a consultation, or at least a discussion about the case over the telephone with one of the rehab facilities. If he accepts, he may have the help of the rehab center team to assist in the management of the case.

"Under no circumstances would there be any dilution of the attending physician's responsibility for the management of the case unless he chose to seek the consultation of the rehabilitation center," assures the report prepared for The Council by the Rehab Committee.

The Rehab Committee's report explains that "the premise on which this project is based is that the concept of rehabilitation is embraced by most physicians. But because of limited facilities and a relative lack of understanding on the part of many physicians as to the exact nature and role of rehabilitation in the continuance of medical care, they may have patients who are in need of rehabilitation, others who are not channeled into the appropriate facilities, or whose planning for rehabilitation is inappropriate.

"The committee wholeheartedly endorses the program as one which will lead to better communication within the medical profession and which will be of great benefit to patients and physicians alike," it continues.

Importance of Report

The evaluating physician in the Disability Determination Program never sees the private physician's patient. He depends heavily on information supplied by the physician or clinic to assess the severity of the patient's impairment, its expected duration and the extent of his residual functional capacity. The disability decision, therefore, rests largely on the completeness of the medical evidence obtained. A detailed report from the treating source, including objective findings and laboratory procedures, will usually be sufficient for us to evaluate the claim and make a decision.

If a report does not contain all the findings necessary to make a proper decision, one of our reviewing physicians may recontact the medical source. When the medical source does not have the needed objective findings we may purchase an evaluation to obtain the information required. The additional time required may delay the patient's claim, however, and can add up to a significant additional program expense. The MD can help speed the decision on the patient's claim by reporting all relevant data about his medical condition as soon as possible.

Criteria for Evaluating Disability

A person under 65 can receive monthly disability benefits if he has a physical or mental impairment severe enough to prevent him from doing any substantial work for a year or longer. In making disability determinations, our agency uses medical criteria developed by the Social Security Administration. This insures uniform evaluation of all applicants and helps simplify and speed the decision-making process. These criteria were developed with the aid of practicing physicians, major medical organizations and SSA's Medical

(Continued on page 543)

Michigan physicians should know about disability insurance under Social Security

By David P. Gage, MD
Lansing

Every physician should know about the programs for the disabled and blind, administered by the Social Security Administration. The social security amendments passed in 1972 have increased substantially the number of people who are being served, and the MD's assistance and cooperation are critical in assuring prompt, sound decisions on claims for disability benefits filed by patients.

The 1972 amendments provide increased protection for disabled workers and their dependents under the disability insurance program. This law reduces the waiting period from six to five months, extends benefits to certain persons disabled before age 22, makes more blind workers eligible, and extends Medicare coverage to persons who have been entitled to social security disability benefits for two years or more.

Also, as a result of these amendments, the existing federal-state programs of aid to the aged, blind, and permanently and totally disabled will be repealed. In their place a new supplemental security income (SSI) program, totally funded by the federal government, will become effective Jan. 1, 1974. For those who are blind and disabled and in financial need, the law requires that the SSI disability determinations be made under essentially the same standards as the regular social security disability insurance program. The new program will be administered by the Social Security Administration, assisted in Michigan by our Disability Determination Program.

Reporting Medical Evidence

In applying for disability insurance benefits, a person is required to submit medical evidence to support his claim. This evidence usually consists of data from the records of his treating physician, clinic, or other medical source. Our experience with the disability program in Michigan indicates that in about three out of five cases no further medical evidence is needed to make a decision on the claim because the treating source already has enough information on record to provide a good picture of the applicant's condition and how it limits his ability to work.

This medical information may occasionally be requested on the patient's behalf by a social security office—or by the Disability Determination Program. This is the full name of the agency in Michigan that evaluates social security disability claims for Michigan residents. Like agencies in other states, the Disability Determination Program in Michigan includes both physicians and trained disability examiners on its professional staff. They form a team that can handle everything which bears on the disability decision, from the strictly medical issues to a complete assessment of the vocational factors.

With the assistance of our staff of reviewing physicians, we try to make our requests for medical information relate as directly as possible to the condition which the claimant states is the cause of his disability. The goal of the individually tailored request is to ease the medical reporting burden of the busy physician or clinic, without jeopardizing the claimant's right to have his case decided on the basis of all relevant information available.

Doctor Gage is chief medical consultant to the Disability Determination Program of the Vocational Rehabilitation Services of the Department of Education.

Michigan hospital costs down

The rate of increase of Michigan hospital costs went down by almost 25 per cent during 1971 from the previous year, according to the Michigan Hospital Association. Operating costs for Michigan community hospitals rose 16.16 per cent during 1971, compared with a 21.52 per cent hike during 1970. This is the largest increase reduction for Michigan hospitals since 1962.

REHAB/Continued

Advisory Committee.

The complete criteria of our disability insurance program, including the medical findings listed by body system, are contained in a handbook designed especially for professionals who come in contact with the disabled. The handbook describes impairments in terms of specific symptoms, signs and laboratory findings that are presumed to be severe enough to prevent a person from working for a year or longer.

This handbook may be obtained from the Disability Determination Program, Box 1200, Lansing, Michigan 48904, telephone 517-373-7830. We also welcome inquiries from physicians who wish to know more about the social security disability programs.

Primary care center in Dowagiac popular, praised by MDs

The first primary care center in Southwest Michigan is now in full operation in Dowagiac, following two years of planning by citizens of Cass, Van Buren and Berrien Counties, in partnership with Robert Locey, MD, health officer of the Berrien County Health Department.

Key agents in the center's development have been the Berrien, Cass and Van Buren County Medical Societies, which have worked since the beginning with Doctor Locey on an advisory basis. The county societies have helped establish guidelines for medical care and staff reimbursement.

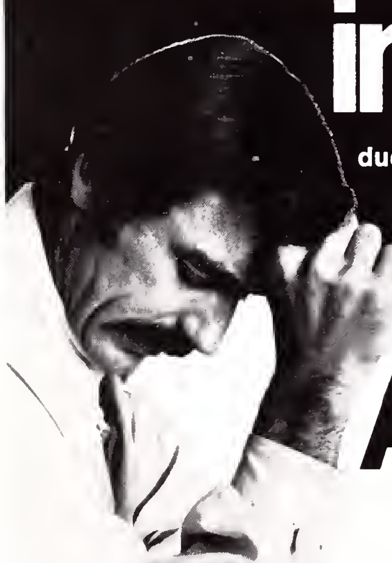
The first full-time physician, Richard Levy, MD, internist and pediatrician, is in service at the Comstock Memorial Family Health Care Center, under the auspices of the national Health Service Corps.

The late David Comstock, MD, for whom the center is named, provided much of the medical leadership in the early phases of planning. Since its opening in October, and until Doctor Levy's appointment in July, the program had the temporary services of E. Dewain Silvernale, MD, Berrien Center, of the Berrien County Health Department Maternal and Child Health Program.

Planning for the center got underway following a primary care study carried out by citizens of the tri-county area which showed Dowagiac as an area of primary care need. The clinic staff includes Doctor Levy, a nurse practitioner, an LPN, a social worker, family health representative and a home health assistant.

A wide economic spectrum of outpatients has been seen. The Comstock Center is initiating a pilot program for the delivery of prepaid total medical care to a selected small group of Medicaid patients, and thus to act as an HMO.

According to Robert K. Lang, MD, secretary, Berrien County Medical Society, local physicians assess the new clinic as being "very successful."



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NEW CLINICAL STUDY

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Fertility and Sterility, January 1970
Official Journal of the American Fertility Society

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Double-Blind Study and Type of Patient: 100 patients suffering from impotence. Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% on placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

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Methyl Testosterone . . 2.5 mg. Thyroid Ext. (1/6 gr.) . . 10 mg. Glutamic Acid . . . . 50 mg Thiamine HCL . . . . 10 mg	Methyl Testosterone . . 5.0 mg. Thyroid Ext. (½ gr.) . . . 30 mg. Glutamic Acid . . . . 50 mg. Thiamine HCL . . . . 10 mg.	Methyl Testosterone . 12.5 mg. Thyroid Ext. (1 gr.) . . . . 64 mg. Glutamic Acid . . . . 50 mg. Thiamine HCL . . . . 10 mg.	Methyl Testosterone . . 2.5 mg. Thyroid Ext. (¼ gr.) . . . 15 mg. Ascorbic Acid (Vit. C) . 250 mg. Thiamine HCL . . . . 25 mg. Glutamic Acid . . . . 100 mg. Pyridoxine HCL . . . . 5 mg. Niacinamide . . . . 75 mg. Calcium Pantothenate . 10 mg. Vitamin B-12 . . . . 2.5 mcg. Riboflavin . . . . 5 mg.
Dose: 1 tablet 3 times daily.	*Dose:* 1 tablet 3 times daily.	*Dose:* 1 or 2 tablets daily.	*Dose:* 2 tablets daily.
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REFER TO PDR

Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiorenal disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension

Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium snd water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.

Hypercalcemia may occur, particularly in immobilized patients· use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References: 1. **Monteseno, P., ond Evengeliste, I.** Methyltestosterone-thyroid treatment of sexu impotence. Clin Med 12 69, 1966 2. **Oublin, M. F.** Treatment of impotence with methyltestosteron thyroid compound West Med 5-67, 1964 3. **Titett, A. S.** Methyltestosterone-thyroid in treating impotenc Gen Prac 25 6, 1962 4. **Hellman, L., Bradtow, H. L., Zumott, B., Fukushima, O. K., snd Gallagher, T.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19-93 1959 5. **Farris, E. J., and Cotton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesi J Urol 79 863, 1958 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Phil delphia. 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomss, Springfield, Ill., 1959, pp. 79-99.

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He has Trichomonas vaginalis?

It’s his infection but her problem...

Men with trichomonal infection are virtually always asymptomatic, which is why they seldom know they have the disease. But many do have it, nevertheless.

Trichomonal infection is so common that estimates[1] indicate one out of every four women of reproductive age has the disease. *Almost half of the husbands of women infected with* Trichomonas vaginalis *have it, too.*[2-9]

CONCURRENT THERAPY WITH FLAGYL PROVIDES ALMOST CERTAIN CURE FOR BOTH OF THEM.

- It is the most effective drug available for the treatment of trichomoniasis in both men and women.
- In men, it eliminates infection from the genitourinary tract.
- In women, it eliminates trichomonal infection from the vagina, the paravaginal crypts, cavities, and glands.
- Consistent cure rates above 90 percent are to be expected. The rate often approaches 100 percent.
- Simple, sure treatment for women: One 250-mg. tablet three times daily for ten days.
- Simple, sure treatment for men: One 250-mg. tablet twice daily for ten days concurrent with treatment of the female partner.
- Side effects are generally mild and infrequent.
- Flagyl is economical because it is so effective.

Flagyl® can cure them both.

(metronidazole)

Indications: For the treatment of trichomoniasis in both male and female patients and in the sexual partners of patients with a recurrence of the infection provided trichomonads have been demonstrated by wet smear or culture. The oral tablets are indicated also for acute intestinal amebiasis (amebic dysentery) and amebic liver abscess.

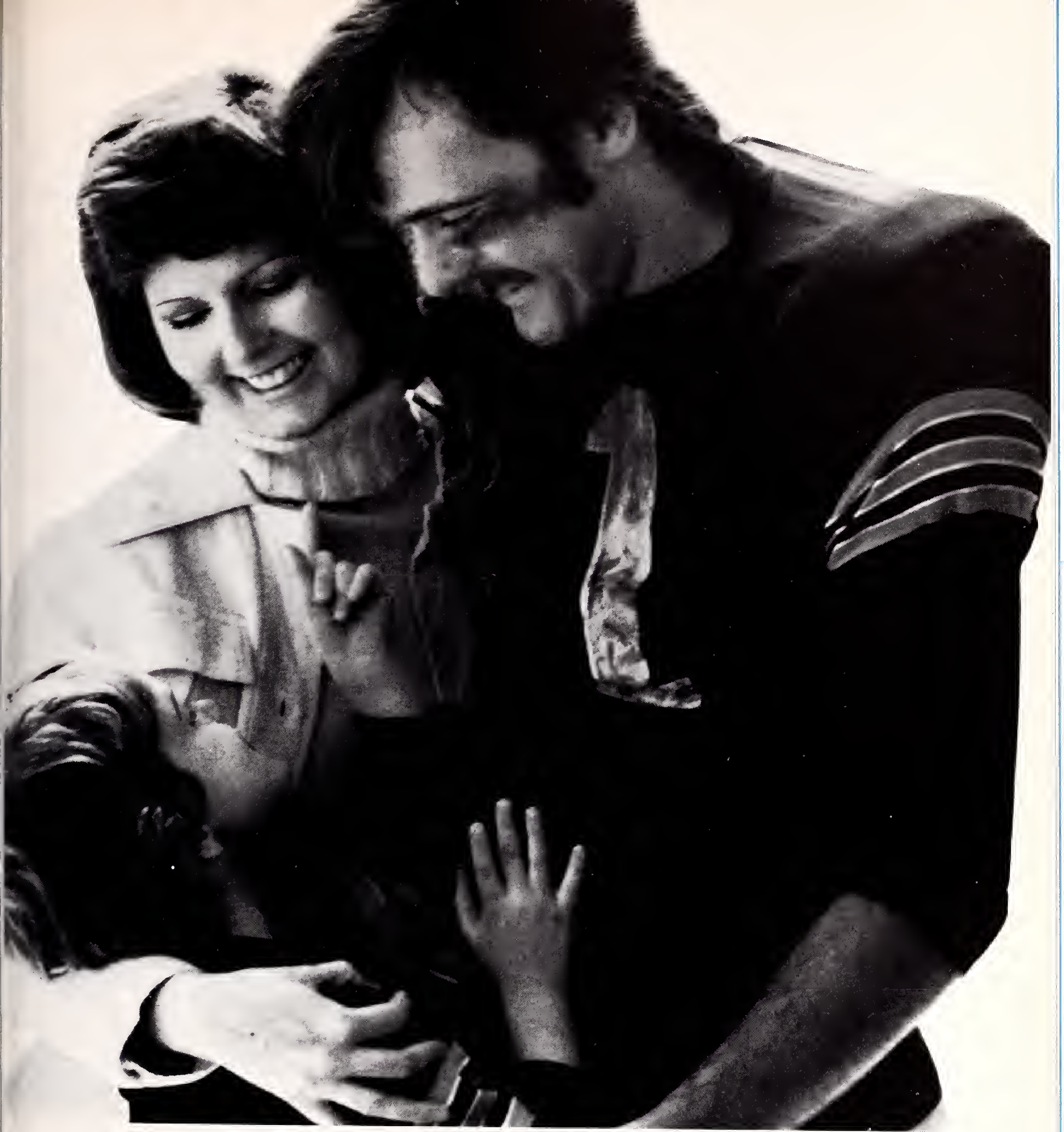
Contraindications: Evidence or history of blood dyscrasia, active organic disease of the CNS, the first trimester of pregnancy and a history of hypersensitivity to metronidazole.

Warnings: Use with discretion during the second and third trimesters of pregnancy and restrict to those pregnant patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers. It is not known whether this can be injurious to the newborn.

Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. Exacerbation of moniliasis may occur. In amebic liver abscess, aspirate pus during metronidazole therapy.

Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia*, exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weakness," urticaria, flushing, dryness of the mouth, vagina or vulva, pruritus, dys
cystitis, a sense of pelvic pressure, dyspareu
fever, polyuria, incontinence, decreas
libido, nasal congestion, proctitis, pyuria
darkened urine have occurred in patient
ceiving the drug. Patients receiving Fl
may experience abdominal distress, nau
vomiting or headache if alcoholic bever
are consumed. The taste of alcoholic be
ages may also be modified. Flattening of
T wave may be seen in ECG tracings.

**Dosage and Administration: For Tri
moniasis.** *In the female:* One 250-mg. ta
orally three times daily for ten days. Cou
may be repeated if required in especially s
born cases; in such patients an interval of
to six weeks between courses and total and
ferential leukocyte counts before, during,
after treatment are recommended. Vagina
serts of 500 mg. are available for use, par
larly in stubborn cases. *When the vagina
serts are used,* one 500-mg. insert is placed



he vaginal vault each day for ten days and oral dosage is reduced to two 250-mg. tab- daily during the ten-day course of treat- ıt. Do not use the vaginal inserts as the sole n of therapy. *In the male:* Prescribe Flagyl when trichomonads are demonstrated in urogenital tract, one 250-mg. tablet two es daily for ten days. Flagyl should be taken ɔoth partners over the same ten-day period n it is prescribed for the male in conjunc- with the treatment of his female partner.

Amebiasis. *Adults:* For acute intestinal biasis, 750 mg. orally three times daily 5 to 10 days. For amebic liver abscess, 500 '50 mg. orally three times daily for 5 to 10 s. *Children:* 35 to 50 mg./kg. of body ght/24 hours, divided into three doses, ly for ten days.

sage forms: Oral tablets 250 mg.
Vaginal inserts 500 mg.

References:

1. Perl, G., and Ragazzoni, H.: Flagyl in Treatment of "Trichomonas Vaginalis" Vaginitis, Obstet. Gynecol. *19*:595-598 (May) 1962. **2.** Kean, B. H.: Trichomoniasis in Males (Letters to the Journal), J. A. M. A. *186*:273 (Oct. 19) 1963. **3.** King, A. J.: Current Therapeutics: CLVI.—Metronidazole in the Treatment of Trichomonal Infections, Practitioner *185*:808-812 (Dec.) 1960. **4.** Watt, L., and Jennison, R. F.: Clinical Evaluation of Metronidazole: A New Systemic Trichomonacide, Br. Med. J. *2*:902-905 (Sept. 24) 1960. **5.** Watt, L., and Jennison, R. F.: Metronidazole Treatment of Trichomoniasis in the Female, Br. Med. J. *1*:276-279 (Feb. 3) 1962. **6.** Teton, J. B., and Treadwell, N. C.: Evaluation of a Systemic Trichomonacide, Obstet. Gynecol. *21*:356-362 (March) 1963. **7.** Durel, P.; Roiron, V.; Siboulet, A., and Borel, L. J.: Systemic Treatment of Human Trichomoniasis with a Derivative of Nitro-Imidazole, 8823 R. P., Br. J. Vener. Dis. *36*:21-26 (March) 1960. **8.** Bertrand, P., and Leulier, J.: Essais cliniques sur la trichomonase des partenaires des femmes infestees (Proceedings of the 1st Canadian Symposium on Non-Gonococcal Urethritis and Human Trichomoniasis, Montreal, 1959), Gynaecologia *149*:93-96 (Suppl.) 1960. **9.** Poole-Wilson, D. S.: The Diagnosis and Management of Chronic Infection of the Bladder, Practitioner *186*:429-437 (April) 1961.

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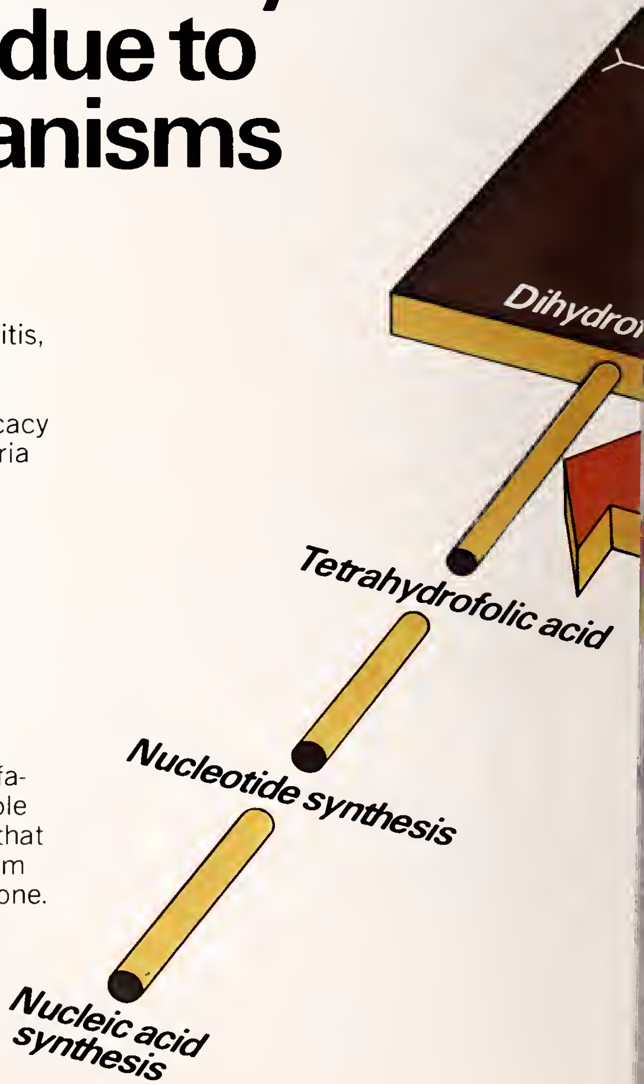
ROCHE announces new BACTRIM™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

a new type of antibacterial for a two-pronged attack against chronic urinary tract infections due to susceptible organisms



Bactrim is highly effective in the treatment of these infections—primarily pyelonephritis, pyelitis and cystitis, when due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species). This efficacy is related to the unique mode of action against bacteria (see opposite page), an action that, in effect, makes Bactrim a new type of antibacterial.

Bactrim significantly superior to constituents in patients with obstructive complications

In the presence of obstructive uropathy, Bactrim has demonstrated efficacy which is superior to either sulfamethoxazole or trimethoprim alone against susceptible organisms. In addition, *in vitro** studies have shown that bacterial resistance develops more slowly with Bactrim than with either trimethoprim or sulfamethoxazole alone.

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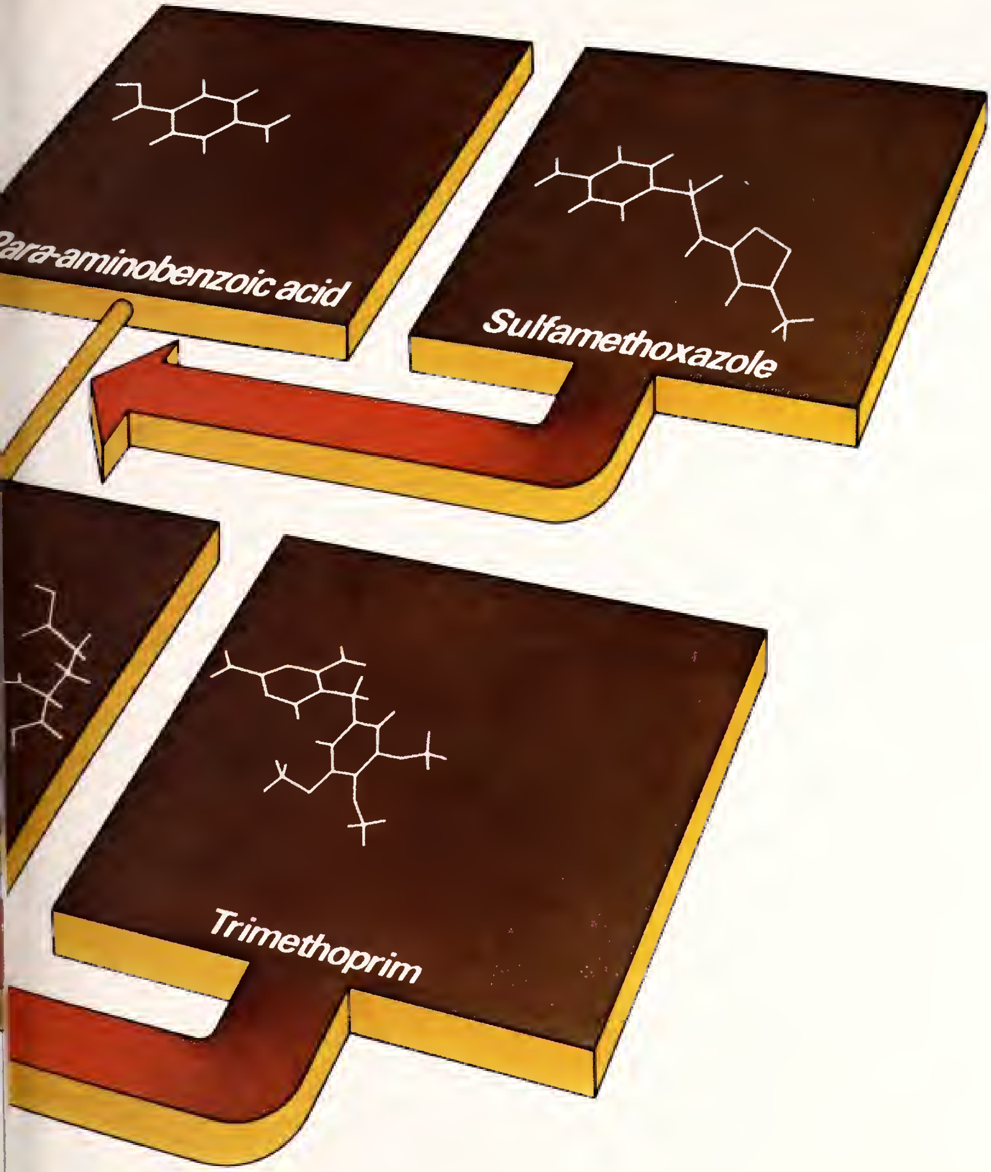
*Please note that clinical conclusions cannot be extrapolated from *in vitro* studies.



ROCHE

nterrupts life cycle of susceptible bacteria

nique mode of action interrupts the life cycle at two important points, thereby impeding e production of nucleic acids and proteins essential to these bacteria. These consecutive terruptions occur because sulfamethoxazole and trimethoprim resemble naturally existing bstrates. By competitive replacement of these substrates, they inhibit further synthesis.

new **BACTRIM**™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

Before prescribing, please see complete product information on last page of advertisement.

Excellent clinical response in chronic urinary tract infections

A multiclinic, double-blind study* of response to a ten-day course of therapy in 471† patients with chronic urinary tract infections demonstrated the superiority of Bactrim. On the 10th day after initiation of therapy, 91.7% (of 168 patients) showed significant bacteriological response to Bactrim compared with 81.2% (of 144 patients) to trimethoprim and 64.5% (of 155 patients) to sulfamethoxazole. In patients with obstructive complications, 10th day response was 94.8% (of 97 patients) to Bactrim, 72.9% (of 85 patients) to trimethoprim and 58.5% (of 94 patients) to sulfamethoxazole.

Excellent response maintained

Bactrim proved equally impressive in maintaining this bacteriological response. In the above study, after ten-day therapy with Bactrim, 68.4% of patients with chronic urinary tract infections maintained response for up to 42 consecutive days, compared with 59.7% with trimethoprim and 44.4% with sulfamethoxazole. In patients with obstruction, 70.8% of those on Bactrim maintained response for up to 42 consecutive days, compared with 49.4% on trimethoprim and 38.8% on sulfamethoxazole. The figures are particularly remarkable in cases with urinary obstruction—cases regarded as being notoriously difficult to treat.

To date, low incidence of significant side effects

Although Bactrim demonstrated impressive clinica results, it is important to note that the incidence of clinically significant adverse effects was low, mainl nausea and/or vomiting, rash, leukopenia, SGOT increase and creatinine increase.

Bactrim should be given with caution to patients with impaired renal or hepatic function, possible folate deficiency and to those with severe allergy c bronchial asthma. Adequate fluid intake must be maintained. Complete blood counts, urinalyses wi careful microscopic examination, and renal function tests should be performed during therapy.

Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatmen of chronic and recurrent urinary tract infections.

Usual adult dosage: two tablets every twelve hour for 10 to 14 days; no loading dose required.

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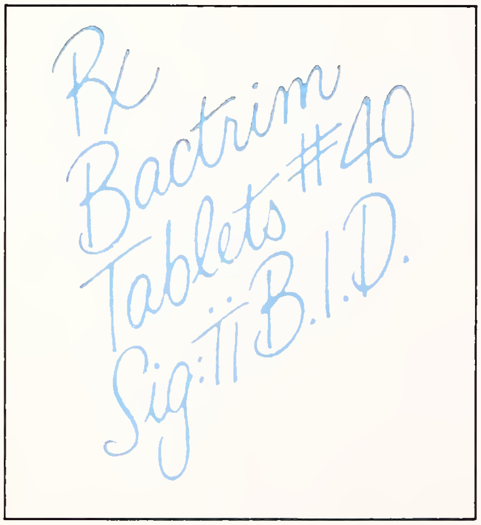
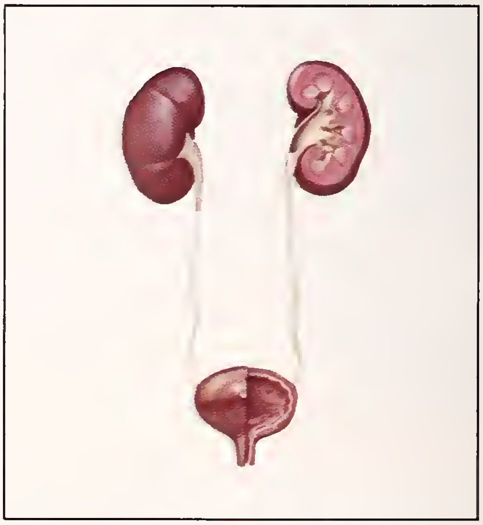
* Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110

† 4 patients not available for evaluation at day 10.



Rx
Bactrim
Tablets #40
Sig: ii B.I.D.



new **BACTRIM**™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

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Before prescribing, please consult complete product information on facing page.

Complete Product Information:

Description: Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. It is a white to light-yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is N^1-(5-methyl-3-isoxazolyl) sulfanilamide. It is an almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

Actions: *Microbiology:* Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with *para*-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

In vitro studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

In vitro serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa*. The following organisms are usually susceptible: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis* and indole-positive proteus species.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms
(MIC—mcg/ml)

Bacteria	Trimethoprim alone	Sulfamethoxazole alone	TMP/SMX (1:20)	
			TMP	SMX
Escherichia coli	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
Proteus spp. indole positive	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
Proteus mirabilis	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
Klebsiella-Enterobacter	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

Human Pharmacology: Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. On repeated administration, the steady-state ratio of trimethoprim to sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma decreases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than are the concentrations in the blood. When administered together as in Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis*, and, less frequently, indole-positive proteus species).

***Important note:* Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.**

Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period (see Reproduction Studies).

Warnings: Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombopenia with purpura has been reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

Precautions: Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Reactions: For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

Blood dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

Gastrointestinal reactions: Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

C.N.S. reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

Miscellaneous reactions: Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

Dosage and Administration: Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

How Supplied: Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

Reproduction Studies: In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

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Ancillary

Kalamazoo hospitals turning education over to corporation

Officials at Borgess and Bronson Methodist Hospitals in Kalamazoo have agreed to assign all medical education responsibilities to the southwestern Michigan Area Health Education Corporation.

The corporation's primary project will be to assume the operation of programs for the undergraduate and graduate and continuing education for physicians in the area. This will include present internships and residencies in operation at both hospitals.

Robert M. Nicholson, MD, has been named executive director of the corporation, reporting to a board of directors made up of 17 people interested in medical education. The corporation president is Roland R. Springgate, MD.

Harper, Grace to merge

Two of Detroit's oldest and largest hospitals — Grace and Harper — have agreed in principle to merge. A special committee consisting of the administrators and trustees of both hospitals has been named to develop a merger plan and timetable.

The merger probably will consolidate both hospitals' facilities in the Detroit Medical Center with the addition of three floors on top of the Webber Memorial Building, now nearing the end of construction by Harper Hospital. The total beds available eventually will number 1,509.

Medical schools simplify admissions

Michigan's three medical schools have cooperated in setting up a simplified admission procedure for prospective medical students which allows the students to request and receive an early decision from their first-choice medical school before seeking acceptance elsewhere. If he's accepted, the future student need not expend the time, funds and effort of applying to other medical schools. The program will be in effect for the entering classes of 1974 and also will eliminate much paperwork and expensive processing done by admissions committees.

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The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25:*134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Michigan mediscene

Sept. 6 — Professional Activity Study and Medical Audit Program Institute, sponsored by Commission on Professional and Hospital Activities, at CPHA headquarters, 1968 Green Road, Ann Arbor, acceptable for AAFP elective hours, contact: CPHA, 1968 Green Road, Ann Arbor, 48105.

Sept. 10-12 — 26th Annual Conference on Aging, "Women—life span challenges," sponsored by U-M and WSU Institute of Gerontology, contact: The University of Michigan Extension Service, 412 Maynard St., Ann Arbor, 48104.

Sept. 19 — The Council, MSMS headquarters, contact: Warren Tryloff, director

Sept. 20-23 — Regional meeting, American College of Physicians, Otsego Ski Club, Gaylord, contact: Muir Clapper, MD, WSU School of Medicine, 540 E. Canfield, Detroit 48201.

Sept. 26 — Annual Muskegon County Trauma Symposium, Holiday Inn, Muskegon, contact: G.W. Anessa, MD, 1470 Peck St., Muskegon, 49441.

Oct. 4-5 — Annual Harold C. Mack Symposium on the Physicology and Pathology of Human Reproduction, "Regulation of Fertility," at headquarters of Engineering Society of Detroit, contact: Kamran S. Moghissi, MD, C.S. Mott Center, 275 E. Hancock, Detroit, 48201.

Oct. 7-11 — 108th MSMS Annual Session, Sheraton-Cadillac Hotel, Detroit, with MSMS House of Delegates to meet Oct. 7-9, contact: Richard Campau, MSMS headquarters; MSMS Scientific Sessions to follow, Oct. 10-11, contact: Helen Schulte, MSMS headquarters.

Oct. 8-10 — Annual meeting of the MSMS Auxiliary, Pontchartrain Hotel, contact: Mrs. Dwight J. Dutcher, convention chairman, 711 S. Oxford Road, Grosse Pointe, 48236.

Oct. 12-15 — Annual Convention, American Speech and Hearing Association, Cobo Hall, Detroit, contact: Barbara J. Nunn, Kenny-Michigan Rehabilitation Foundation, Seminole at West Huron, Pontiac, 48053.

Nov. 28-30 — Physician postgraduate course, "Human Hypersensitivity Disorders: Clinical Aspects and Pathogenetic Mechanisms," sponsored by American College of Physicians, at U-M Medical Center, contact: ACP, 4200 Pine St., Philadelphia, 19104.

Nov. 20 — Professional Activity Study and Medical Audit Program Institute, sponsored by Commission on Professional and Hospital Activities, at CPHA headquarters, Ann Arbor, acceptable for AAFP elective hours, contact: CPHA, 1968 Green Road, Ann Arbor, 48105.

Jan. 15 — Midwinter board meeting, MSMS Auxiliary, at MSMS headquarters, contact: Mrs. William J. Jones, president-elect, 15839 Crescent Drive, Allen Park, 48101.

March 18-21 — Physician postgraduate course, "Rheumatic Diseases: Pathogenesis, Diagnosis and treatment," sponsored by American College of Physicians, at U-M Medical Center, contact: ACP, 4200 Pine St., Philadelphia, 19104.

April 24 — Annual Legislative Day, MSMS Auxiliary, at Olds Plaza Hotel, Lansing, contact: Mrs. Robert J. Westerhoff, 2458 Maplewood, SE, Grand Rapids, 49506.

April 24-25 — Annual Spring Conference, MSMS Auxiliary, at Hospitality Inn, Lansing, contact: Mrs. William J. Jones, president-elect, 15839 Crescent Drive, Allen Park, 48101.

AMA Judicial Commission underlines its stand on physicians, advertising

The MSMS Judicial Commission wishes to call the attention of Michigan physicians to a recent reaffirmation by the AMA Judicial Commission of its stand on the use of a physician's name in commercial advertising.

The AMA Council, noting that "Commercial advertisements carrying the name, photograph and professional appointments of physicians are conspicuous in both public and profession periodicals," has re-emphasized its position that such activity is "demeaning" and that "a physician should not allow his name or the prestige of his professional status as a physician to be used in the promotion of commercial enterprises.

"To the extent that the facts of a particular case indicate that the honor and dignity of the profession are denigrated then charges of conduct contrary to Section 4 of the Principles of Medical Ethics should be brought before and fully reviewed by the ethics committee of the physician's component medical society," adds the reaffirmation.

Therapeutic radiologists form new organization

A new organization, the Michigan Society of Therapeutic Radiologists, has been formed for educational, scientific and charitable purposes. Membership is open to physicians in Michigan, neighboring states and Canadian provinces. Meetings are to be conducted bimonthly during the academic year. Officers are Robert J. Bloor, MD, Royal Oak, president; Juan V. Fayos, MD, president-elect, and A.G. Fleurquin, MD, secretary-treasurer.

Kellogg Foundation aiding programs to improve burn care

An $848,680 Burn Care Development Program in the Great Lakes region will be underwritten by a grant from the W.K. Kellogg Foundation.

Half the grant, or $436,680, goes to The University of Michigan Burn Center, directed by Irving Feller, MD, whose team will: 1) design and prepare training programs for health care teams to treat burn patients and 2) assist communities in developing their own burn care programs and facilities.

Balance of the grant ($412,000) will go to a community assistance program to construct approximately 100 beds for burn patients in six states, including Michigan and Ontario, Canada.

New hospital underway in Ann Arbor

Ground was broken June 24 for the new St. Joseph Mercy Hospital just east of Ann Arbor. The new hospital will replace the former St. Joseph Mercy Hospital in the city limits. It will have 558 beds as well as surgical, medical and coronary intensive care units. The hospital, being built at a cost of $36,602,000, is to be completed in 1976.

Manual available for medical examiners

Michigan physicians interested in becoming medical examiners may wish to purchase the Manual for Medical Examiners by Robert C. Hendrix, MD, professor of pathology at the University of Michigan and Deputy Medical Examiner of Washtenaw County.

The book is designed specifically for the physician who serves as a part-time medicolegal investigator and has relatively little experience or training in the subject.

The publisher is Charles C. Thomas, Springfield, Ill., and the price is $6.75.

As of Jan. 1, all Michigan counties were required by a law passed in 1969 to eliminate their county coroners and instead certify deaths by medical examiners, who must be physicians.

MSMS supported the change in the law, which was modified in the summer of '72 to say that the medical examiner may designate a law enforcement officer or other representative to go to the place where the body lies.

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Brief Summary

Indications—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

Contraindications—Drug hypersensitivity and porphyria.

Warnings—Not recommended during the first and second trimester of pregnancy. Caution patients of possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

Precautions—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitryptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

Adverse Reactions—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 307454

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Michigan Foundation elects new board

At the annual meeting of the Michigan Foundation for Medical and Health Education June 20, four board members were elected. Returned to the board were Robert K. Whiteley, MD, Detroit; A. Stewart Kerr, who also serves as MSMS legal counsel, and Herbert H. Garner, retired Detroit banker, John R. Ylvisaker, MD, who is the MSMS treasurer, was elected to fill the board vacancy caused by the death in 1972 of G. Thomas McKean, MD, Detroit.

The foundation's grants in 1972 amounted to $11,092.12 for several projects and for financial assistance to Michigan medical students.

Small doses

Alfreds A. Birzgalis, MD, Ionia,

has retired after 12 years as medical superintendent of Ionia State Hospital. He has been on the Ionia staff for 21 years, the second longest period of time that any state mental hospital superintendent has been in service.

James A. Ferguson, MD, Grand Rapids,

was the recipient of the 1973 Distinguished Alumni Award as part of commencement ceremonies at Grand Rapids Junior College. He also was honored by Welch Allyn, Inc., for his contributions to the advancement of medical instrumentation.

Herbert B. Fowler, MD, East Lansing,

is new medical superintendent of the Kalamazoo State Hospital. He succeeds Clarence M. Schrier, MD. Doctor Fowler is currently associate professor of psychiatry and director of a multidisciplinary continuing education program in the MSU Department of Psychiatry.

C. Jackson France, MD, Harper Woods,

was among three Wayne State University faculty members to receive alumni awards at the recent WSU Alumni Reunion. Doctor France, a member of the WSU clinical surgery faculty, is past president of the School of Medicine Alumni Association and the Wayne State Fund. He is a director of the WSU Alumni Association and chairman of the Finance Committe of the Anthony Wayne Society. He received an MD degree from WSU in 1942.

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Jack Georges, MD, Cheboygan,

is the 1973 nominee to the Cheboygan High School Honor Society's Hall of Fame. Doctor Georges is a native of Cheboygan and exemplifies to the students the old-fashioned family doctor.

Thomas J. Greene, MD, Detroit,

is one of 11 physicians named by HEW Secretary Caspar Weinberger to serve three-year terms on the National Professional Standards Review Council. Doctor Greene, a cardiovascular surgeon, represents the National Medical Association.

W. Leonard Howard, MD, Muskegon,

is new president of the Muskegon County TB and Respiratory Disease Association. He succeeds David A. Amos, MD.

Karl G. Klicka, MD, Wayne,

is new first vice president of the Michigan Hospital Association. He was elected at the recent annual convention of the MHA. Doctor Klicka is also executive director of the Peoples Community Hospital Authority in Wayne.

Ronald L. Krome, MD, Detroit,

is a new member of the board of directors of the American College of Emergency Physicians. Re-elected to the board are John H. van de Leuv, MD, Lake Orion, and John G. Wiegenstein, MD, Lansing.

John W. MacKenzie, MD, Swartz Creek,

is new president of the Human Services Planning Council serving Genesee and Lapeer counties.

MDPH Centennial honors 11 physicians

In this, its centennial year, the Michigan Department of Public Health has singled out a number of Michigan physicians for special honors. Recognized as persons who "over the years have contributed so much of their talents and energies to the furtherance of public health objectives," they are recipients of the Centennial Awards presented by MDPH Director Maurice S. Reizen, MD.

The physicians are James Acocks, MD, Marquette; Goldie Corneliuson, MD, Ft. Meyers, Fla., and Drummond Island; Otto K. Engelke, MD, Ann Arbor; John Isbister, MD, Lansing; Albert Heustis, MD, Three Rivers; Matthew R. Kinde, MD, Battle Creek; Frederick Margolis, MD, Kalamazoo; Lorenzo Nelson, MD, Baldwin; Virgil Slee, MD, Ann Arbor; Oscar Stryker, MD, Kalamazoo, and V.K. Volks, MD, Saginaw

Doctor MacKenzie formerly was president of the Flint-area Council of Social Agencies and has served on the United Fund Board of Trustees.

Glenn E. Moore, MD, Flint,

is new president of the Michigan Society of General Surgeons. He will serve for a year. Other new officers are Homer M. Smathers, MD, Detroit, president-elect, and William Olson, MD, Ann Arbor, secretary-treasurer. They were elected at the society's recent annual meeting in Ann Arbor.

George W. Morley, MD, Ann Arbor,

is new president of the Michigan Society of Obstetrics and Gynecology. Doctor Morley is chief of the U-M Medical Center Gynecology Service, editorial board member of the U-M Medical Center Journal, and a governor of the U-M Medical Center Alumni Society.

Austin Smith, MD, Detroit,

has retired as chairman of the board of Parke-Davis Co. He will continue as consultant and will devote more time to educational, philanthropic and other health care pursuits. Doctor Smith was the recipient of an MSMS National President Award in 1972 for his leadership of the International Federation of Pharmaceutical Manufacturers Associations.

Donald P. Stratton, MD, Muskegon,

director of radiation therapy at Hackley Hospital, has been appointed to the new Governor's Radiation Advisory Committee. The committee will serve the governor and the Michigan Department of Public Health, to review radiation regulations currently being drawn up by the MDPH, to help the department establish good medical practice in radiation therapy and to advise the governor on any issues regarding radiation.

Scott N. Swisher, MD, East Lansing,

is new head of the medical advisory committee of the American National Red Cross blood program. He will serve a three-year term. Doctor Swisher is a member of the National Heart and Lung Institute panel on blood transfusion and has served national and local Red Cross blood programs for the past 15 years. He is chairman of the MSU College of Human Medicine Department of Medicine.

H.C. Tien, MD, Lansing,

director of the Michigan Institue of Psychosynthesis, has returned to his native land, China, for a summer-long visit. He plans to study the country's mental health services and will return to the United States in September.

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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County scenes

Jackson MDs sponsor Explorers

Members of the Jackson County Medical Society are sponsors of a new Medical Explorers Post. Meetings began in April and have included tours of the local hospital and a presentation on the function and activities of the emergency room.

Invitations were sent to over 200 high school juniors and seniors who had indicated an interest in health careers. The first meeting brought a turnout of nearly 80.

The post leaders include Clifford E. Keeler, MD, and Larry E. Jennings, MD, assisted by Lois A. Harrison, MD, and Bruce F. Knoll, MD. One of the objectives is to develop a core of Jackson physicians willing to lend time and knowledge to young people with an interest in health careers.

Northern Michigan MDs Tackling local drug abuse

Dialogue with local police officers, judges, teachers, school administrators, government agencies and social services personnel is the outgrowth of a bold step taken by the Northern Michigan Medical Society late in June.

The NMMS Drug Abuse Committee, with the endorsement of the larger society, mailed approximately 2,500 letters to the parents of all children in the local school district, warning them that there was increased abuse of drugs by their children. Included with the letter was a reprint of an article in the Journal of the American Medical Association that warned recently of the dangers of marijuana use by adolescents and young adults.

The Society's Drug Abuse Committee has recommended a three-part program to be promoted within the community. It includes (1) curtailment of currency in the hands of adolescents, (2) increased harassment of known drug dealers and increased support of police efforts to control drug traffic, and (3) elimination of unchaperoned parties and continuous informing of parents as to their children's whereabouts.

"We're trying now to educate ourselves and to figure out how to get the whole community working together," explains Robert A. Mengebier, MD, committee member.

Members of the committee include Russell F. LaBeau, MD; John Lypski, MD; Robert E. Shanahan, MD, and Robert A. Mengebier, MD.

KCMS members welcoming mew house staffers

At the urging of its Education Committee, the Kent County Medical Society has instituted a policy of warmly welcoming new house staff physicians in the Grand Rapids area.

Following completion of the intern matching program this May, the Kent Society sent letters of welcome to all 50 interns and other new house staff designated to serve in Grand Rapids hospitals. The letters invited the house staff members to attend Kent County meetings and become members.

"The response has been pretty affirmative," says E.L. Moorhead, II, MD, chairman of the KCMS Education Committee. "It's my estimate that we will have half of the new doctors joining us when meetings resume in September.

"I think sending the letters is a good move. It gets the new, young physicians into the society, and that's where all the business is." Doctor Moorhead promoted the idea last spring to Carl H. Moberg, MD, KCMS president, who is now sending out the letters.

Macomb Society has new emergency committee

A new Emergency Medical Service Committee has been formed by the Macomb County Medical Society to coordinate physicians' contributions to a new county-wide move to improve emergency medical services.

The Macomb County Board of Commissioners is leading efforts of MDs, osteopaths, police, firemen, ambulance personnel, hospitals and other interested groups in the county. Eventually it is expected that the county improvements will be tied into better emergency service in southeast Michigan, the state and nation.

The immediate goal, according to MCMS Committee Chairman Edward Maxim, MD, is to apply for and obtain a grant of approximately $400,000 from the Robert Wood Johnson Foundation. The deadline is this month, and if approved, the program will begin in January.

The combined Washtenaw forces hope to purchase telemetry equipment with the grant for better emergency communications, to help develop a coordinated emergency training program for ambulance technicians, firemen and policemen and to further coordinate all emergency services.

Serving on the WCMS committee with Doctor Maxim are Earl G. Moehn, MD, Mt. Clemens; Joseph J. LaHood, MD, Mt. Clemens; Leland C. Brown, MD, and Stanley Engelhardt, MD, Mt. Clemens.

UP physicians, clergy planning second meeting

Upper peninsula physicians and clergymen are looking forward to their Second Annual Upper Peninsula Conference on Medicine and Religion following a successful and well-received first conference late last spring.

Conceived and carried out by a committee of four local clergymen and R.F. Ziegler, MD, director, Department of Cardiology, St. Joseph's Hospital, Hancock, the first conference attracted 60 MDs and religious leaders for a discussion of "Health Wholeness."

They met in Houghton and were addressed by John O. Simenstad, MD, Osceola, Wis., chairman, Committee on Medicine and Religion, Wisconsin State Medical Society; and The Rev. Robert Reeves, chaplain and director of chaplain training at Columbia-Presbyterian Medical Center, New York.

Doctor Ziegler, who until three years ago was with Henry Ford Hospital in Detroit, had attended a medicine and religion meeting in Alma. Finding that meeting worthwhile, he carried the memory of it with him to the UP, where he initiated action and saw it grow to a UP-wide meeting.

"Those attending received our first annual meeting very enthusiastically," he reports. "We will start our work again in the fall and plan to keep current."

Well mothers insured by Bay area doctors

Members of the Bay-Arenac-Iosco counties Medical Society have been volunteering their time and skills to a new "well-mother" clinic held weekly in the General Division of the Bay Medical Center, formerly Bay City General Hospital.

The clinic was founded a year ago by C. E. Chute, MD, chief of staff at the center, assisted by a BAICMS committee made up of W. J. Stansell, MD; John C. Mayne, MD, and Donald B. Garvin, MD. Now nearly all Bay County obstetricians are volunteering to work at the clinic on a rotating basis.

The clinic purpose is to insure that no woman will go through a pregnancy without medical care. It serves those who have been unable to get help before for various reasons, about 25 women per week. They are seen once a month until the seventh month, then every two weeks until the ninth when they are seen every week until delivery.

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PRECAUTIONS Prolonged dosage of androgen may result in sodium and fluid retention This may present a problem, especially in patients with compromised cardiac reserve or renal disease In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

CONTRAINDICATIONS Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast Contraindicated in the presence of severe liver damage.

WARNINGS: If priapism or other signs of excessive sexual stimulation develop, discontinue therapy In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastic breast carcinoma. If this occurs, the drug should be discontinued.

ADVERSE REACTIONS: Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastic breast carcinoma This usually indicates progression of bone metastases. • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia

DOSAGE AND ADMINISTRATION Dosage must be stricly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as an average daily dosage guide.

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WANTED: Fulltime staff physician for 320 bed hospital with rehabilitation, psychiatric and tuberculosis units. Michigan license required. Excellent salary and fringe benefits. Reply: Robert A. Clowater, M.D., Medical Supt. Saginaw Community Hospital, Saginaw, Michigan 48605.

OTOLARYNGOLOGIST—Board eligible or certified. Need third associate in expanding 50 member specialty clinic in Michigan. All types of ENT work done. Beautiful summer and winter recreation area. Many corporate fringe benefits. Starting salary competitive. For Information, Write D.C. Elliott, M.D., Burns Clinic, Petoskey, Michigan 49770.

PSYCHIATRISTS: Full or Part Time. Young Adult Institute, Detroit, Michigan a multi-disciplined psychiatric program for youths, has opening for Psychiatrists on a 20 or 40 hour per week basis. Program has in-patient facility and community centers covering Northwest and Northeast Detroit. Salary according to qualifications. $25,000 to $30,000 per year for full time position. Excellent fringe benefits provided by Michigan Civil Service. Call or write: M. Kemal Goknar, M.D. Director Young Adult Institute, 1151 Taylor, 4th Floor, Detroit, Michigan 48202. (313) 224-6882. An equal Opportunity Employer.

IMMEDIATE OPENING for OB-GYN, Internal Medicine, and Orthopedic specialties to establish successful practice with 14 man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

STAFF PSYCHIATRISTS: Community oriented State of Michigan agency. Affiliated with Wayne State University (faculty appointment available); active teaching program ongoing in all disciplines. Salaries range from $25,600-$33,500 (depending on qualifications) plus liberal fringe benefits. Apply: Medical Director, Detroit Psychiatric Institute, 1151 Taylor, Detroit, Michigan 48202.

NOW LEASING 2760 sq. ft. New Building, scheduled for completion early fall, in fast growing Romeo, Michigan. The new home of Ford Mtr. Tractor Division Headquarters, downtown, ideal for a Clinic. Contact: Hammond Realty, 125 W. Lafayette St., Romeo, Michigan 48065.

UNIVERSITY HEALTH PHYSICIAN—ATHLETIC MEDICINE COORDINATOR: Staff position available for M.D. in Detroit. Position includes responsibility to athletic programs of the University plus general clinic duties. Competitive salary and fringe benefits including retirement and disability programs offered. Experience in managing athletic injuries desirable. For information send vitae to Andrew J. Smith, Jr., M.D. Director, Health Service, Wayne State University, Detroit, Michigan 48202. The University is an Affirmative Action/Equal Opportunity Employer.

MEDICAL SERVICE STAFF PHYSICIAN—Board certification in Internal Medicine preferred. 200 bed modern general hospital with active medical and surgical services. Salary dependent upon qualifications. Excellent fringe benefits. Can pay moving expenses. License any state required. Equal opportunity employer. Contact Hospital Director, Veterans Administration Hospital, Fort Wayne, Indiana 46805 or call (219) 743-5431, Ext. 310.

PATHOLOGIST—Board Certified, Anatomic and Clinical Pathology. Age 31 years. Seeks position, preferably close to Ann Arbor. University affiliated trained. Call (313) 487-5210 Usha Kumra, M.D., 2124 Nancy St. Ypsilanti, Michigan 48197.

DIRECTOR OF MENTAL HEALTH

We are seeking a psychiatrist to direct the Milwaukee County Mental Health Center, a comprehensive community mental health center, organized into six catchment area programs including outreach stations located within the community. 1,000 acute and long-term psychiatric beds; an ultra modern day hospital; and, a soon to be completed 180 bed inpatient resident and day care treatment center for children and adolescents. The Center is a principal psychiatric teaching resource for the Medical College of Wisconsin and has training programs for interns, residents, nurses and other students.

Requires Wisconsin licensure or eligibility for same and at least 5 years' comprehensive experience as a mental health director, educator, or administrator preferably in an accredited mental health program, university or hospital.

This is a timely opportunity since we can offer the person appointed to this position the chance to make several critical appointments to new subordinate positions. Excellent employe fringe benefit program and salary. Send vita to:

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In memoriam

Joseph C. Brisson, MD
Sterling Heights

Joseph C. Brisson, MD, Sterling Heights, died June 5 at the age of 62.

Doctor Brisson was a graduate of Wayne State University School of Medicine and was on the staff of Deaconess Hospital, Detroit. His death followed a long illness.

Luther W. Day, MD
Lantana, Fla.

Luther W. Day, MD, longtime Jonesville physician who retired to Florida last year, died May 14.

Doctor Day, a native of Ohio, was the third generation of his family to receive his medical degree from the Eclectic Medical College in Cincinnati. He practiced in Ohio, Texas and Michigan, establishing his medical office in Jonesville in 1936. He remained active until 1965.

Doctor Day was past president of the Hillsdale County Medical Society, former chief of staff of the Hillsdale Community Health Center and a 25-year delegate to the MSMS. He was a member of the National Association of Eclectic Medical College Alumni and of the American Academy of Family Physicians.

Owen C. Foster, MD
Detroit

Owen C. Foster, MD, Detroit obstetrician-gynecologist, died May 14 at the age of 81.

Doctor Foster was a graduate of the University of Louisville medical school and came to Detroit in 1916 as an intern. He joined the staff of Harper Hospital the next year and had been there since.

In 1960, while still a bachelor, Doctor Foster was named Detroit's "Father of the Year," for the thousands of babies he had delivered. The total finally reached approximately 8,000.

Henry H. Hartkop, MD
Detroit

A lifelong resident of Detroit, Henry H. Hartkop, MD, died May 4 at the age of 73. He was a psychiatrist.

Doctor Hartkop was graduated from Wayne State University School of Medicine and was on the staffs of The Haven and St. Clair Hospital. He was a clinical instructor in psychology at WSU School of Medicine and belonged to the Michigan Society of Neurology and Psychiatry and the American Psychiatric Association.

Emil M. Roth, MD
Plantation, Fla.

Former Grand Rapids physician Emil M. Roth, MD, died June 26 at the age of 67.

Doctor Roth was former chief of staff at Butterworth Hospital, Grand Rapids, where he also had served as vice chief of surgery and vice chief of staff. He retired in 1967, but continued to spend the summers in the Grand Rapids area.

Doctor Roth was a graduate of the University of Michigan Medical School. He was a fellow of the American College of Surgeons.

Medico-legal

The AMA's Citation *newsletter, prepared by the AMA Law Department, lists the following cases involving health personnel in Michigan. Persons interested in obtaining more information on individual cases may write MSMS headquarters.*

"Statute of limitations
in wrongful death action"
Michigan Court of Appeals, May 24, 1972
from *The Citation,* Vol. 26, No. 5, Dec. 15, 1972

"Optometrist suspended
for incompetence"
Michigan Court of Appeals, April 28, 1972
from *The Citation,* Vol. 26, No. 7, Jan. 15, 1973

"Medical publication may be used in cross-exam o
medical expert"
Michigan Supreme Court, Aug. 30, 1972 from *Th*
Citation, Vol. 26, No. 12, April 1, 1973.

"In Michigan abortion proscecution, state mus
prove lack of necessity" Michigan Court o
Appeals, Aug. 23, 1972, *The Citation,* Vol. 27, No
1.

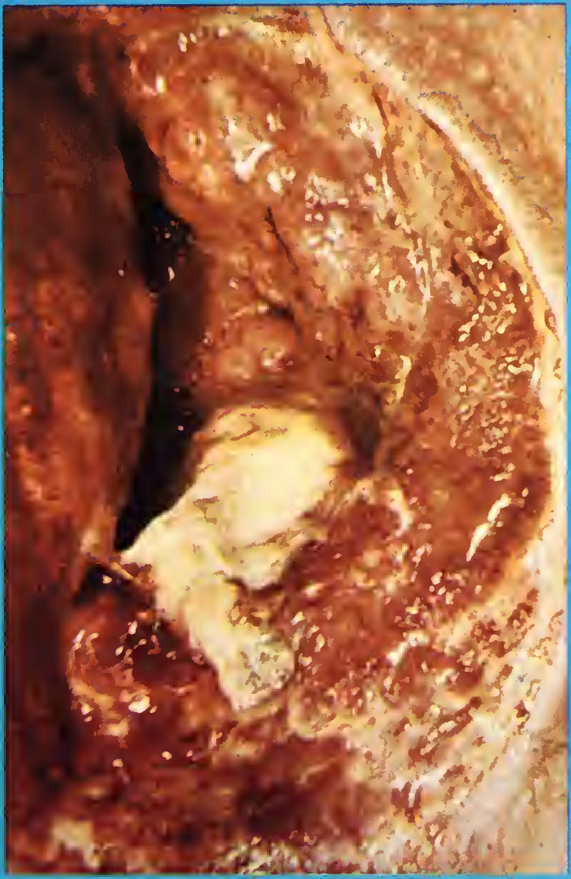
"Physician convicted in Michigan when abortio
performed improperly" Michigan Court o
Appeals, Aug. 23, 1972, *The Citation,* Vol. 27, No
1.

"Interns, residents and fellows held to b
employees" Michigan Supreme Court, Feb. 20
1973 from *The Citation,* Vol. 27, No. 5

Decubitus Ulcers Yield to

Travase® Ointment
brand of Sutilains

Before treatment, necrotic matter coated the inner surfaces of this decubitus ulcer.



After six days of TRAVASE therapy, debridement is nearly complete and granulation evident.

ıctive Therapy—Observe Its Effects in 48 hours
ı the recommended nursing technique is
ıed without deviation, this procedure can
rate visible improvement within 48 hours of
nent. If no dissolution of slough occurs by then,
er application is unlikely to be rewarding
eck for break in procedure, usually due to use
ansing or antiseptic agents which impair the
ıveness of the enzyme in TRAVASE).

ıl observation and photos by Kathleen Brough
n, M.D., Marion County Home, Indianapolis, Ind.

e see next page for prescribing information

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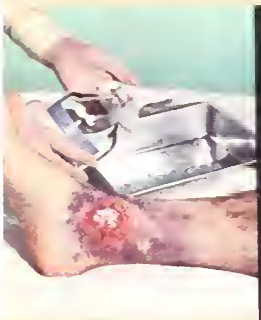
Travase® Ointment brand of Sutilains

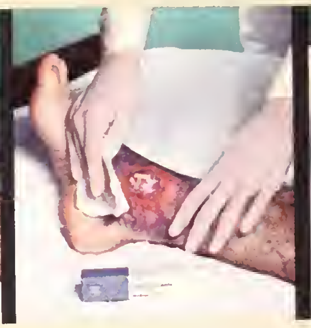
APPLICATION TECHNIQUE: TRAVASE Ointment is indicated as an adjunct to established methods of wound care for biochemical debridement. It dissolves and facilitates the removal of necrotic tissues and purulent exudates.

TRAVASE enzymes are selective. Virtually inactive on viable tissue.

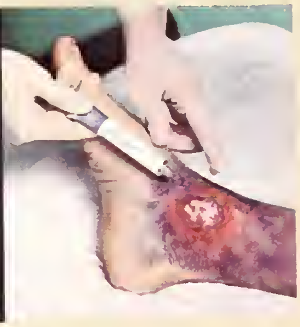
When this recommended nursing technique is followed without deviation, this procedure can generate visible improvement within 48 hours . . .



(Ulcer being irrigated) Thoroughly cleanse and irrigate the wound area using only sterile water or sodium chloride solution. Be sure to cleanse the wound of any antiseptics or heavy-metal antibacterial agents which may interfere with the enzyme activity.

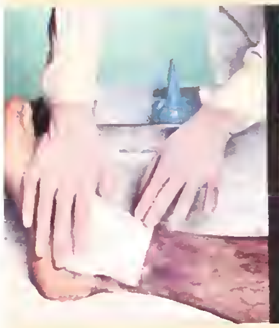


Thoroughly soak the wound area. Where practical, tubbing or showering is suitable. Or wet soaks with gauze pads may be used. Remember to avoid chemical cleansing agents which may interfere with the therapy.

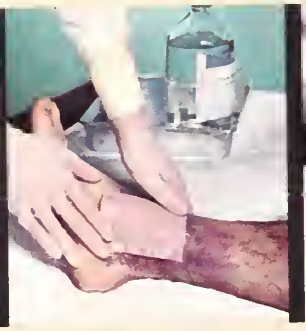


With a sterile cotton swab or finger cot, apply a very **thin** layer of TRAVASE Ointment. The ointment spreads easily and only a small amount is needed (a small dab of ointment will cover an area as big as the back of a hand).

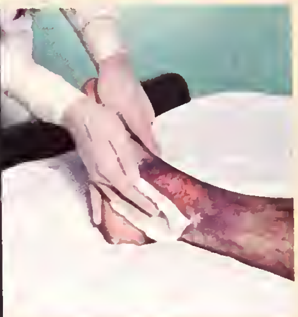
Be sure, though, to rub the ointment well into every crack or crevice of the wound and overlap the surrounding skin one-fourth to one-half inch beyond the area to be debrided—to be sure of complete coverage.



Apply loose, wet dressings, thoroughly soaked in sodium chloride solution or sterile water to the area to be debrided only.



Cover the moist dressings with an occlusive wrap (Saran wrap, Telfa Pads, or other plastic wrappings) to keep wound site moist. Do not extend occlusive wrap over ½ inch beyond area to be debrided.



When changing dressing, gently wipe away the dissolved material. Repeat the complete dressing procedure, including application of TRAVASE Ointment, four times daily.

The ulcer shown in these photos is simulated on a model in order to demonstrate the correct TRAVASE application technique.

To: FLINT LABORATORIES
Division of Travenol Laboratories, Inc.
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Please send:

_____ Additional Information on TRAVASE® Ointment (brand of Sutilains)

_____ In-service training program

_____ Comment _______________________________

DESCRIPTION: TRAVASE® (brand of sutilains) Ointment is a sterile
preparation of proteolytic enzymes, elaborated by **Bacillus subtilis,**
hydrophobic ointment base consisting of 95% white petrolatum and
polyethylene. One gram of ointment contains approximately 82,000 c
units* of proteolytic activity.

ACTION: TRAVASE Ointment selectively digests necrotic soft tissue
proteolytic action. It dissolves and facilitates the removal of necroti
tissues and purulent exudates that otherwise impair formation of
granulation tissue and delay wound healing (4).

At body temperatures these proteolytic enzymes have optimal activi
the pH range from 6.0 to 6.8.

INDICATIONS: For wound debridement (1,2)—TRAVASE Ointment is
indicated as an adjunct to established methods of wound care for
biochemical debridement of the following lesions:

Second and third degree burns,
Decubitus ulcers,
Incisional, traumatic, and pyogenic wounds,
Ulcers secondary to peripheral vascular disease.

CONTRAINDICATIONS: Application of TRAVASE (brand of sutilains
Ointment is contraindicated in the following conditions:

Wounds communicating with major body cavities,

Wounds containing exposed major nerves or nervous tissue,

Fungating neoplastic ulcers,

Wounds in women of child-bearing potential—because of lack
laboratory evidence of effects of TRAVASE upon the developin

WARNING: Do not permit TRAVASE Ointment to come into contact
the eyes. In treatment of burns or lesions about the head or neck,
the ointment inadvertently come into contact with the eyes, the eye
be immediately rinsed with copious amounts of water, preferably s

PRECAUTIONS: A moist environment is essential to optimal activit
enzyme. Enzyme activity may also be impaired by certain agents. I
several detergents and antiseptics (benzalkonium chloride,
hexachlorophene, iodine, and nitrofurazone) may render the substr
indifferent to the action of the enzyme (3). Compounds such as thi
containing metallic ions interfere directly with enzyme activity to a
slight degree, whereas neomycin, sulfamylon-streptomycin, and pe
do not affect enzyme activity. In cases where adjunctive topical th
has been used and no dissolution of slough occurs after treatment
TRAVASE Ointment for 24 to 48 hours, further application, because
interference by the adjunctive agents, is unlikely to be rewarding.

In cases where there is existent or threatening invasive infection,
appropriate systemic antibiotic therapy should be instituted concu

Although there have been no reports of systemic allergic reaction
humans, studies have shown that there may be an antibody respon
humans to absorbed enzyme material.

ADVERSE REACTIONS: Adverse reactions consist of mild, transie
paresthesias, bleeding and transient dermatitis. Pain usually can
controlled by administration of mild analgesics. Side effects sever
enough to warrant discontinuation of therapy occasionally have o

If bleeding or dermatitis occurs as a result of the application of T
(brand of sutilains) Ointment, therapy should be discontinued. No
toxicity has been observed as a result of the topical application o
TRAVASE Ointment.

Dosage and Administration

STRICT ADHERENCE TO THE FOLLOWING IS REQUIRED FOR E
RESULTS OF TREATMENT

1. Thoroughly Cleanse and Irrigate Wound Area with sodiu
or water solutions. Wound **MUST** be cleansed of antisept
heavy-metal antibacterials which may denature enzyme o
substrate characteristics (e.g., Hexachlorophene, Silver
Benzalkonium Chloride, Nitrofurazone, etc.).
2. Thoroughly moisten wound area either through tubbing,
or wet soaks (e.g., sodium chloride or water solutions).
3. Apply TRAVASE Ointment in a thin layer assuring intimal
with necrotic tissue and complete wound coverage exten
¼ to ½ inch beyond the area to be debrided.
4. Apply loose wet dressings.
5. Repeat entire procedure 3 to 4 times per day for best re

How Supplied

3P3002 TRAVASE Ointment is supplied sterile in one-half ounc
(14.2 g.) containing 82,000 casein units of sutilains per
hydrophobic ointment base.

The ointment must be stored under refrigeration at 2° to 10° C
(35° to 50° F).

References

1. Garrett, T. A. **Bacillus subtilis** protease, a new agent for debri
Clin. Med. **76**: 11-15, 1969.

2. Hesterberg, R. (Necrosis treatment on fermentative basis). Do
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Dissertation Printing: Charlotte Schoen, Munich, 1964. (Ger.)

3. Howes, E. L. The healing of the burn may be hindered by its
therapy. 20th Cong. Soc. Inter. Chir., Rome, Italy, September 14-

4. Prytz, B., Connell, J. F., Jr., and Rousselot, L. M. **Bacillus su**
protease in the digestion of burn eschar. Clin. Pharmacol. Thera
347-51, 1966.

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*A casein unit is the amount of enzyme required to produce the
optical density at 275 mμ as that of a solution of 1.5 mcg. tyros
after the enzyme has been incubated with 35 mg. of casein at
one minute.

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Digest of Proceedings

MSMS House of Delegates
1973 Spring Meeting
May 13 - 15, Boyne Mountain

House of Delegates Proceedings
1973 Spring Meeting
Michigan State Medical Society

How to Use This Digest:

For your convenient use of the *Digest of Proceedings*, please note the following arrangement of contents:

Each report is followed immediately by the action of the reference committee on that report and then by the House action on the report of the reference committee. Resolutions are printed as they were finally approved or disapproved by the House.

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Call to Order and Special Reports

1. Call to Order

The Spring Session of the House of Delegates of the Michigan State Medical Society, held at the Boyne Mountain Lodge, Boyne Mountain, Michigan on May 13-15, 1973, convened at 8:20 a.m., Vernon V. Bass, MD, Speaker, and James D. Fryfogle, MD, Vice Speaker, presiding.

2. Invocation

The Speaker called upon A. Stewart Kerr, the Parliamentarian, to give the invocation.

3. Report of Committee on Credentials

Chairman Fred C. Brace, MD, reported a quorum seated, the majority of whom were not from any one county.

4. Report of Committee on Rules and Order of Business

Chairman James C. Danforth, Jr., MD, reported that the Committee on Rules and Order of Business held its meeting April 3, 1973. Speaker Vernon V. Bass, MD, Vice-Speaker James D. Fryfogle, MD, and Secretary Kenneth H. Johnson, MD, were present as guests of the Committee.

Order of Business for 1973 Spring Session. The Committee amended and approved a draft of the Order of Business for printing in the Delegate's Handbook.

Optional Informational Meetings for Delegates. The Committee is pleased that special arrangements for optional informational meetings for delegates on Professional Standards Review Organizations and Medicaid have been scheduled as an adjunct to the Spring Session. These optional meetings have been scheduled for the afternoon of Monday, May 14, to give delegates an opportunity to discuss important developments first hand with committee members working in these two vital areas. If interest warrants, these meetings may be continued after the dinner hour.

Seating and Tenure of Delegates. The Committee noted that the House of Delegates at the 1972 Annual Session adopted changes in the MSMS Bylaws, Chapter 9, Section 4, which provide that "A Delegate, or in his absence, an Alternate Delegate (in order of seniority) becomes a member of the House of Delegates when duly registered and seated at the Annual Session following his election and certification by the component County Society. If a Delegate is not present, his place may be taken during the period of his absence by an Alternate Delegate from the same component County Society."

Site for 1974 Spring Session. Speaker Bass discussed with the Committee the results of his site visitation for the 1974 Spring Session. His findings will be reported to the delegates as part of the Speaker's Remarks and his recommendations will be considered by the Reference Committee on Rules and Order of Business.

Authorization to Recess Proceedings. The Committee again recommends to the House of Delegates, as it has for the last three years, that the House vest in the Speaker the authority to recess its proceedings to a time certain, at his discretion, and without the necessity of the vote of the body. Such vesting of authority will constitute the only departure from Robert's Rules of Order, which we recommend otherwise govern the proceedings of the 1973 House of Delegates.

THE HOUSE adopted the report of the Committee on Rules and Order of Business.

5. Speaker's Remarks—Vernon V. Bass, MD

The Speaker outlined the plans and procedures of the House. He announced that optional informational meetings on PSRO and Medicaid would be held in the Snowflake Lounge on May 14, as listed in the order of business.

He also reported on possible site selections for the 1974 Spring Session. After his investigation of various sites, he made the following recommendations:

1. That the 1974 Spring House of Delegates Session be held in Freeport, Bahamas, leaving Detroit by charter flight on Sunday, March 24, and departing the Bahamas on March 27 by charter flight.
2. That should enough members want to benefit from the lower convention rates, a later charter flight leaving Sunday be offered.
3. That since any member of the Michigan State Medical Society can and should testify before reference committee, the membership of MSMS be apprised of these opportunities for an educational vacation to participate and witness the House of Delegates in action.

REFERENCE COMMITTEE ON RULES AND ORDER OF BUSINESS, James C. Danforth, Jr., MD, Chairman, recommended disapproval of the recommendations.

THE HOUSE approved the recommendation of the Reference Committee.

(The following report of the Speaker was presented to the delegates in printed form.)

This is a brief review of the implementation of resolutions adopted by the 1972 House of Delegates. (For complete text of resolutions with House Action, refer to the *Digest of Proceedings, Michigan Medicine*, Vol. 72, No. 1.)

Resolution
Number

72A-1 — *Control of Promotion and Sale of Medical and Disability Insurance Policies.* Follow-up discussion has been held with the Insurance Commissioner. No action has developed yet.

72A-2 — *Physician Service in Outpatient Departments.* The Judicial Commission returned the resolution to the Speaker indicating that the resolution in its present form was not within the jurisdiction of the Commission.

72A-3 — *The Defense of Physicians by the MSMS.* The Committee on Utilization Review and Health Insurance Problems reminded members in the April *Medigram* that existing guidelines for MSMS peer review programs provide mechanisms for physicians to file complaints about third party payors, which prevent the physician from obtaining appropriate reimbursement for his services.

72A-8 — *Change in Prescriptions for Ritalin.* Restrictions have been placed on Ritalin at the Federal level.

Resolution Number

The issue was referred to the American Medical Association which is following the request.

72A-9 – *Selection of MDs for Paramedical College Instructors.* Letters were sent to universities, colleges and community colleges to carry out the directions of Resolution 72A-9.

72A-10– *Signing Medicaid Provider Agreement of Department of Social Services.* Following adoption of Resolution 72A-10, an ongoing liaison between MSMS and State government re Medicaid was appointed at the request of the Governor. A separate report will be presented to the 1973 Spring House of Delegates.

72A-11– *House of Delegates Seat for Medical School Deans.* This resolution was referred to the Constitution and Bylaws Committee, which has studied it and will report to this House.

72A-12– *Separate County Chapter Status for Gratiot County.* Separate charters have been issued to Gratiot County and Isabella-Clare Counties, as instructed by this resolution.

72A-13– *Rehabilitative Care and Legislation.* This resolution calls for state legislative action to require plaintiff posting of surety bond in malpractice actions, which would be forfeited if the defendant won the case, and to seek AMA action along the same line. Specific bill has not been introduced pending legislative study of malpractice in its entire scope. AMA has adopted resolution calling attention to the California bond law by each state society.

72A-15– *The Michigan Abortion Referendum.* As authorized by this resolution the MSMS position has been included in the official listing of the MSMS policy. The MSMS Department of Communications and Professional Information issued various news releases throughout the year telling the public about the MSMS policy position.

72A-18– *Consent by Staff Patients.* This resolution, which would require that emergency room patients be advised of the availability of private medical care, has been referred to the Committee on Hospital Relations for study.

72A-19– *Exploitation of Physicians.* The Judicial Commission returned the resolution to the Speaker indicating that the resolution in its present form was not within the jurisdiction of the Commission.

72A-20– *Manual for Medicaid Recipients.* MSMS has consistently urged the Department of Social Services to publish a Manual of Benefits and has offered MSMS assistance.

72A-22– *To Assist our Patients in the Distribution of their Health Insurance Dollar.* The feasibility of doing a comparative cost analysis of the various health care plans in Michigan was investigated by the Bureau of Economic Information. Unfortunately, the Michigan Insurance Commission would not allow the study since it said that incomplete comparisons were unlawful, and that no comparison could be conducted that would meet their standards.

72A-24– *County Society Membership for Licensure.* This resolution has been referred to The Council, as instructed. The Council has requested an opinion from Legal Counsel re the legality of such a requirement. The Council will consider the legal opinion on May 13.

72A-25– *Medicare Emergency Room Regulations.* A resolution was introduced at the November 1972 AMA House of Delegates meeting as instructed in the resolution.

72A-26– *Re-endorsement of the Usual, Customary and Reasonable Fee.* The Council has referred this problem to the Liaison Committee on Medicaid for appropriate implementation.

72A-27– *A Resolution of Information for Physicians When They Leave Their Community.* The message in Resolution 72A-27 was reported to MSMS members in various issues of *Michigan Medicine* and the *Medigram.* The May issue of *Michigan Medicine* will carry an article by Speaker Bass about the matter again so physicians understand the "ethical implications of assigning patients to emergency or other broadscope services during absence from practice."

72A-28– *Study of Health Care in Michigan's Penal Systems.* A Committee is being appointed by The Council to carry out the study, as instructed by this resolution.

72A-29 –*Physician Manpower for Rural Areas.* This resolution was referred to the Committee on Rural Medical Services, which has established liaison with the Michigan State University School of Medicine for the purpose of offering assistance in determining the feasibility of setting up community-based medical training programs in the upper peninsula.

72A-30– *Medical Malpractice.* This resolution directed MSMS to support, and urged AMA to instigate, federal legislation to provide adequate funding for rehabilitation of chronically ill and disabled. Michigan delegation to AMA introduced such a resolution which was adopted by AMA House of Delegates. Issue now lies with AMA staff in Washington.

72A-31– *The Drinking Driver Problem.* This resolution calls for MSMS support for additional legislation to control drinking driver problem. MSMS supported 1972 legislation lowering implied consent blood alcohol content from .15 to .10, and keeps abreast of other approaches through its Committee on Highway Injuries. Legislation now is proposed to repeal the 18-year-old minimum drinking age in view of rise in accidents among 18-21 year old group.

72A-32– *Patients' Rights Relative to Privileged Communication & the State Department of Mental Health.* MSMS was informed on December 4, 1972, that the Michigan State Department of Mental Health dropped their attempts to push this matter. They did this shortly after the passage of Resolution 72A-32 by MSMS House of Delegates.

6. President's Remarks—John J. Coury, MD

You know, it is amazing what happens when you go from president-elect to president. You lead a relatively peaceful life until that happens, and then suddenly the phone starts to ring, newspaper articles are written, newspaper reporters are on the phone, all the members (particularly the disgruntled ones) write you letters or call you by phone, the home office calls, and all kinds of decisions have to be made.

Last October, when I took over, this House of Delegates more or less declared war, and it was a pretty tough ultimatum to get going into office with the Medicaid situation. We had both sides of the fence, with our feet planted in cement. Your officers felt that something had to be done, and I felt we should give a brief history as to what happened. If there is any blame from anyone who was disgruntled with the action taken, the buck stops right here, as they say.

We had an emergency meeting; and because certain members knew the governor, we then had a meeting with the governor the next day in Lansing. From there on we developed our ad hoc negotiating committee with regard to Medicaid. This committee was picked primarily because of

House, Council and geographical distribution. I think the committee did an outstanding job, taking a nightmarish situation and reducing it to one that I feel is satisfactory. After going throughout the state, I would say most men are satisfied with what has gone on by this committee, and I must compliment this committee for its hard work, its sincerity, and its ability to get a job done.

I am sure everybody isn't going to be pleased. Jim Fryfogle I am sure will give you the details on all this. But let me say this, gentlemen: When you are going to declare war on something and you don't have any battle plans, and no bullets for your guns, then you have to sit down and try to be reasonable, and negotiate something. I think this committee has done a great job.

I feel this particular type of thing should be carried out in the future with regard to important committees of the Society. I will have more to say about this in October. But when you permit a committee that is negotiating for you to have some authority to make a decision without coming back to The Council, and The Council stewing over it and finally coming back to the House, and six months going by (or whatever the time may be), the battle is lost. I feel that in the future important committees appointed by this House or in combination with the House and the leadership should have some authority to make decisions for you in your absence.

It has been a really pleasurable six months or so to date—a little longer than that. Brooker Masters and Bob Leitch and I have tried to share responsibilities. We have tried to make a point of getting around to all county organizations and other organizations as well. We have not accomplished this. We have a few more months to do it. We feel this should be an ongoing policy for all future officers, no matter who they might be.

I am deeply convinced that the leadership in this organization must get around to all county societies, to the grassroots level, to learn to know these men and to get to know just what is going on in Lansing and what is being done or not being done for them. In the past I think most of it has been done by one man, and I think there just isn't enough time for one man to do it. Brooker and Bob have been great to work with, as have other officers of the society. I think we are accomplishing this task.

There are a few things I would like to leave with you. I know you are going to be discussing some of them, and I would like to give you my feeling about some of them.

PSRO is here. You know it. There are many of you who will state, "We will have nothing to do with it; we are not even going to consider it. Let's let it go down the drain or the sewer and we will be the better off for it."

I think it is great to be prideful, it is great to be an individual and all that, but we have to think (1) of our patients, (2) of the Society as a whole, and (3) ourselves as well.

I plead with you to become more unified in your thinking, to become more actively participating in soliciting membership in this organization. We have only about 80 per cent of the physicians in Michigan. There isn't any question in my mind that continuing medical education is going to be something in the future. I think with all of this we can resolve some of the problems with the PSRO. Whether you know it or not, PSRO was put out to help contain some of the costs of the Medicare and Medicaid program. Illinois and Ohio have already proved—particularly Illinois, which has the most sophisticated computer setup so far in its test program, has shown that it costs $14 per patient for a review. This isn't going to decrease costs any, but the law is here. It must be in effect by January 1974, that is, if an organizational plan is to be made and presented and carried out by the physicians of this country. If it is not done, then the government will put in its own review board, so to speak.

I can also assure you (and I feel this is true) that if it is a success it is going to be a government success, and if they fail because of a stupid law or a foolish one, in a way, it is going to be our fault. But we are caught in this bind, and I think we have to do what we can with the most and with the best.

I plead with you not to just say, "Forget it; it's going away." It isn't going to go away. It is the law of the land. I feel we should get organized, do something about it, try to make the best of it, and if we don't like it then let's try to get it changed. But I don't think we should be at the point of disobeying the law and then cutting our throats in the meantime by ignoring it, and have nothing to present to the bureaucratic system that is in Washington with regard to how it is going to function.

I honestly feel it can be worked into an educational opportunity for physicians all over the country in bringing in continuing medical education. If you have a good utilization review system in your hospital, I don't think it is going to be any different. I don't have blinders on me when I say this. If you have a good utilization review committee I think you have nothing to fear.

If you practice quality medicine you won't have anything to fear, but I think we should come out (if we are going to object to this law) and state it isn't going to contain the cost of Medicare and Medicaid, that it is going to increase the cost, and explain in a rational fashion to the people, the consumers or anybody else interested, why it is going to do this.

I cannot visualize a bureaucratic system so large that they are going to be able to review every Medicare and Medicaid patient hospital-wise as well as office-wise. This will probably be the biggest bureaucracy in the city of Washington, D.C. or the country.

What I am pleading for from here on in is unity and reasonableness. Gentlemen, your officers and your Council and those we appoint or elect as chairmen are out to do a job for everybody. I know we can't please 100 per cent of the people, but we would like those who are displeased to be reasonable with the men who are working for you, and have some patience. Democracy is slow, but it usually wins out.

7. Remarks from the Chairman of the Michigan Delegation to the AMA—Donald N. Sweeny, Jr., MD

Dr. Sweeny was unable to attend the meeting and this portion was deleted from the program.

8. Remarks from Chairman of The Council: Robert M. Leitch, MD

Thank you, Mr. Speaker, delegates, ladies and gentlemen. It is a pleasure to be here and bring you up-to-date on what The Council has been doing.

The minutes of The Council are sent to each delegate during the year so that you are aware of decisions made by The Council each month. As Chairman of The Council, I give a detailed annual report at the Fall Meeting of the House of Delegates and last year began a tradition in providing an interim progress report from The Council to the Spring Meeting of the House.

In my comments today, I would like to highlight and in a way summarize the actions and concerns of The Council during the past several months. Foremost in our concerns have been the many problems with Medicaid. As authorized by the House last fall, the President, Speaker and Chairman appointed a Medicaid Liaison Committee which has reported regularly to The Council its progress in trying to alleviate or resolve the problems that were worrying and maddening doctors. The Governor's office, through the Advisor on Health Affairs, Doctor Don Smith, has met with The Council on one occasion and has been most cooperative in getting the right people from the agencies and provider groups to sit down and discuss the many problems. A good deal of progress has been made, which you will hear later in a direct report from Doctor Fryfogle, who is the spokesman for our Medicaid Liaison Task Force. I would simply like at this time to thank Dr. Fryfogle and the members of his committee, Doctors Siegel, Toteff, Brush, and Lahti, for the tenacity that they displayed in this task and the thoughtful study that they put into seeking solutions to our many problems.

Malpractice. Professional liability insurance problems continue to face us. We were disappointed that the Joint House and Senate Study Committee on Professional Liability did not come up with any dramatic solutions to problems, though there will be some legislation introduced. We have all been further disappointed that the Johnson & Higgins Insurance Consulting Company has not been able to find an insurance company of national repute which would be willing to offer a sponsored plan to Michigan State Medical Society members. Johnson & Higgins are still working, however, and submitted a progress report last month.

At its last meeting The Council appointed an ad hoc committee to study the possibility of MSMS forming its own professional liability insurance company. This weekend several of us have been meeting to try to pull together all of the various efforts that are going on within and without the state medical society into arriving at what might be a practical and achievable goal for the Legislature in 1973.

PSROs. Some fine work on the part of the Governmental Medical Care Programs Committee and its chairman, Bob Rice, MD, of Greenville, led The Council to adopt the committee's recommendation that MSMS ought to coordinate the activities of the development of PSROs in Michigan. We now have a new committee to coordinate PSRO activity. After visiting with HEW officials in Washington, D.C., the coordinating committee, under the chairmanship of Doctor John Wilson of Grand Rapids, has made considerable progress in working with the component societies in coming to some agreement on what the regions ought to be, measured against what will probably be the guidelines set down by HEW. MSMS is not taking a dictatorial role in this area but is simply coordinating the desires of the components to adjoin themselves into regional PSROs that may qualify under the yet to be published HEW guidelines. I won't go into any more details on this except to explain, as I have already done, the role of MSMS up to this point. This is to be the subject of a discussion seminar this afternoon.

Staff. The Council, committees, House of Delegates and the officers have continued to receive the benefit of very fine staff support. Mr. Tryloff has assembled and leads a fine group of talented people.

The major responsibilities for the staff members have not changed substantially but Mr. Tryloff is always fine tuning the responsibilities and departmental objectives to match the changing priorities as set forth by The Council.

Finance. The Finance Committee, chaired by Ernest Griffin, MD, of Flint, has developed a very tight budget for 1973 and is making every effort to see that our dues dollars are going to fund priority projects as defined by the House of Delegates and The Council. Doctor Griffin and members of his committee will be reporting the audit to the Ways and Means Committee at this session. Some preliminary discussions have already been held between the Chairman of the Ways and Means Committee, Doctor David Siegel of Lansing, Doctor Griffin, the treasurer, and staff. MSMS is in the black for 1973 and we envision no change from this unless some emergency occurs. Dr. Ylvisaker will report to the House of Delegates following my report.

Legislative. Since the October meeting of the House of Delegates, MSMS has been active in the legislative arena. We were effective in obtaining a statute designed to establish quality control requirements for Physician Assistants. We have renewed our activity with the Board of Registration in Medicine toward a new and modern medical practice act to replace the 1899 staute now in effect. As directed by The House, we have taken a militant and active position in opposition to legislation which would repeal the Pharmacy Act anti-substitution clause. In the malpractice field we are promoting a bill to grant immunity to physicians, blood banks and hospitals in blood transfusion-related hepatitis cases. And, pursuant to policy, MSMS also supports legislation to enforce the abortion control guidelines drafted, with our help, by the Department of Public Health.

The Doctor-of-the-Week program is working exceedingly well and is one of the best ventures that MSMS has ever put forward on Capitol Hill. The MD presence is extremely visible, and the Legislature appreciates the contributions of these individual practicing physicians who give their time.

The Council is appreciative of the fine work being done by the Legal Affairs Committee Chairman, Thomas Berglund, MD, of Kalamazoo, and by Bruce Ambrose and his MSMS staff.

Member Recruitment. As The Council told the House last fall, we are embarking on membership recruitment and retention, and have assigned full time responsibilities to a staff person to aid the component societies in a recruitment program and to develop and publicize the benefits of membership in MSMS to the new incoming members and prospective members. We are also developing a continuing liaison with foreign medical graduates, who are new members of MSMS, in an attempt to improve MSMS services where they may be needed.

Planning and Priorities. The Planning and Priorities Committee under the stewardship of Stuart Gould, Jr., MD, of Ann Arbor, has made considerable progress in its study and is making to the House of Delegates some recommendations on a portion of the charge that was given it when it was created two years ago. The Council received the report at the same time it was sent to the Delegates. At its meeting yesterday, The Council voted to approve the report and recommend to The House that the recommendations it contains be approved. The report will be presented following my report so I will say nothing more here than to commend the members of that important committee, for the future of MSMS rests on the wise recommendations that are made to The Council and to the House of Delegates.

Liaison with Blue Shield. The Council has recognized that there ought to be liaison between MSMS and the Michigan Medical Service, while at the same time recognizing that the official connection between the two organizations has been severed by action of this House. The official separation, in the opinion of The Council, however, does not mean that there cannot be communication which will be of benefit to the members.

A couple of months ago The Council authorized a study committee to develop appropriate means of liaison with Blue Shield. The original report was referred back to the committee for further refinement and improvement, and at its meeting yesterday The Council adopted the following recommendations:

a) There will be formal meetings, at least semi-annually, between the highest leadership of Blue Shield and MSMS. These will be on the record in the form of minutes. Such meetings are to improve understanding and provide insight to the leadership of each group as to the plans, programs and problems of the other.

b) There will be regular informal meetings with the highest officers of the Blue Shield board. At this level of contact, a much needed two-way line of communication will be achieved. First, MSMS will request that MD members of the MMS board organize in a manner which will permit liaison between MSMS and their group. Second, MSMS will provide staff research and informational aid at the request of the MMS-MD board members. Third, MSMS will provide input into Blue Shield by informing MD board members of plans, programs and problems which concern the policy and administration of MMS.

Relative Value Study. The Council authorized the Relative Value Study Committee to develop a RVS document that would be of more use to the physician and his office assistants by incorporating several of the existing codes.

This was heretofore thought an impossible task, but John Anthony and the Bureau of Economic Research have found a way to accomplish this goal, and the Committee is now awaiting some final figures from one of the specialties. The document will be published in July.

Because the House at its last meeting authorized the publication of the RVS with a single code number of the CPT, The Council had no funds in the 1973 budget remaining in which to publish a second edition with several codes appearing simultaneously. Therefore, The Council authorized the publication of the document to be offered to the members of MSMS at print cost only. This is an innovation, and we hope it will be acceptable, because the document will be very valuable in your office practice.

I would like to thank of the MSMS committee chairmen and their committee members for the great work they do. These gentlemen work untiringly throughout the year; and of course, as previously mentioned, the MSMS staff, without whom we could not function. Hopefully MSMS is becoming an increasingly viable organization that is attempting to take the lead in seeking solutions to the many problems facing doctors today.

This concludes my remarks. I would now like to call on Dr. Ylvisaker for the Report of the Treasurer.

9. Remarks from the Treasurer—John R. Ylvisaker, MD

Good morning. I am going to deviate just a little bit from the method of reporting I have followed in previous years, only because I felt that there are so many new delegates since we started some of our programs that it really isn't significant what we have done in the past as much as it is what we are doing right now.

My remarks will be brief and directed toward providing the House with a broad overview of MSMS fiscal management. Financial information in detail has been provided to the Ways and Means Committee for review.

Let me summarize our general method of operation, provide you with pertinent totals, and then make a few comments.

MSMS operates on a fiscal year from December 1 through November 30. Annual budgets are carefully prepared by the Budget Committee, reviewed in detail and approved by the Chairman of the Finance Committee and by that Committee itself before approval by The Council. The progress of the budget is monitored regularly by the Finance Committee. The Board of Managers supervises investments and reports regularly to the Finance Committee through the Treasurer. Year-end audit is performed annually.

Three basic funds exist:

1. The Operating Fund, or cash account, devoted to current expenses and budget items.
2. The Capital Reserve Fund, maintained for replacement of capital items or for contingencies.
3. The Creative Reserve Fund (Capital Protection), established to provide resources for non-budgetary projects or programs to benefit the Society, its members, or the popplation it services.

Fiscal management is sound. We operate within our budget with a positive cash flow and annually project future needs. The net worth of the Society experiences steady growth and at 1972 year-end was $1,111,000.

Investments are managed on a day-to-day basis by Heber-Fuger-Wendin, a Detroit-based firm. Recently the Board of Managers instituted periodic performance management through our long-standing relationship with Merrill Lynch as an operative device to safeguard the Society.

The following financial summary reflects MSMS status at fiscal year-end, November 30, 1972:

	Total Contributions	Market Value 11/30/72
Operating Fund Balance		$268,000
Capital Reserve Fund	$401,500	477,800
Creative Reserve Fund	385,000	359,200
Total	786,500	837,000
Net Change		+50,500
Headquarters Building Mortgage Balance		603,000

The distribution of investments is summarized at the end of this report for your information.

The budget this year was carefully constructed and pared by Doctor Griffin, Finance Committee Chairman, to avoid dues increase. Projections for 1974 will be reviewed with the House at the fall session.

Let me add a few personal comments. As you can see from the above summary, our investments have provided only a modest growth. I would have preferred to show you a much larger increment but I am happy there is no loss. However, of far more importance is the net effect of our fiscal policies of the recent past. These policies require that we live within our current income, that we properly collateralize and amortise our capital debts and that we provide adequate and growing reserves for capital improvements or contingencies. In addition the policies have provided us with funds which will allow the Society to embark on well-planned programs for member benefits or other creative and positive projects without taxing the membership. To this end, we are now actively engaged in developing the proper utilization of the Creative Reserve Fund in your interests.

Addendum to Treasurer's Report

MSMS Funds

CAPITAL RESERVE FUND HOLDINGS AS OF NOVEMBER 30, 1972:

Stocks—Common	31.3%
Stocks—Preferred	15.3
Bonds and Notes	45.9
Real Estate	7.5
TOTAL	100.0%

CAPITAL PROTECTION FUND HOLDINGS AS OF NOVEMBER 30, 1972:

Stocks—Common	70.4%
Stocks—Preferred	12.4
Bonds and Notes	17.2
TOTAL	100.0%

CURRENT SHORT TERM PAPER HELD FOR THE OPERATION FUND:

Federal Intermediate Credit Bank—$200,000 due January 2, 1974—7%
Federal Intermediate Credit Bank—$100,000 due December 3, 1973—6.61%
Federal Intermediate Credit Bank—$100,000 due October 1, 1973—6.68%
Ford Motor Credit Company—$75,000 due August 13, 1973—6%
$65,000 due on a few days notice—6.99%

1972 RECORD OF FUND MANAGEMENT:

Interest Income	$22,241
Capital Reserve Fund Change*	1,274
Capital Protection Fund Change*	13,413
*(includes dividends & interest earned)	
TOTAL	$36,928
Interest Expense on Mortgage	$38,174

10. Report of the Medicaid Liaison Committee —James D. Fryfogle, MD, Chairman

I will make this relatively brief because we will have a second session on Medicaid that you are all invited to attend this afternoon.

Mr. Speaker and Members of the House:

The report of the Liaison Committee is presented to you with mixed feelings, but the strong accent is on the positive. The wheels of the government turn slowly, but they do turn, and what you really need is a big push to make them turn.

When this House passed a resolution six months ago that urged its membership not to sign a participating agreement with the Department of Social Services, we were sort of at an impasse. The Governor was called into the dispute. Thursday morning following the House of Delegates meeting, your elected leadership met with Governor Milliken and his top staff people in the Governor's office. We found that physicians by their vote, and the government by their stand, were at an absolute impasse. There was nowhere to go with respect to the Provider Agreement. The outcome was that the Governor said this couldn't happen in Michigan, so would our leadership please appoint a committee; he would do likewise, and the two would meet and see what they could do about it.

The Society's Committee was appointed by Dr. Bass, Dr. Coury and Dr. Leitch, chairman of The Council, and consisted of Drs. Brock Brush of Detroit, Paul Lahti of Royal Oak, David Siegel of Lansing, Robert Toteff of Saginaw, and myself.

The Governor's appointed committee consisted of Donald Smith, MD, Director of the Governor's Office of Health and Medical Affairs; John T. Dempsey, PhD, the Governor's personal representative; Maurice Reizen, MD, Director of the State Department of Public Health; R. Bernard Houston, Director of the State Department of Social Services, and Kenneth Frankland, legal counsel to the Governor.

In this brief report I would like to outline the committee's efforts. You will note in your agenda that the speaker has set aside an hour or more this afternoon, from 4:30 to 5:30, in the Snowflake Lounge, and there the entire committee will assemble to answer and clarify for you any questions you may have and may want to take back to your constituency.

Many of the impossible-to-change items such as the Participating Agreement were changed at a single session. It was a learning experience for me and the committee. Many of the bugaboos put out by the government and things we were afraid of just didn't exist. You will recall that Stuart Patterson stood on this rostrum six months ago and told us frankly that very little about the new Participating Provider Agreement could be altered. To the credit of the committee and particularly Dr. Lahti, the new Provider Agreement most of you have signed is simply a matter of record needed for the computer. It gives information necessary for the transmittal of bills to the Department of Social Services. All your signature does is to not commit you to any program but to simply say the above information is true. That got rid of a lot of things that stirred up this House six months ago.

I would like at this time to extend to you the committee's thanks, and to the constituency whom you represent, because you went along so well with this. We gave you a lot of confusing directives—re-sign your signature, sign a new one, hold off; and we tried to do this through the *Medigram.* You responded beautifully, and I thank you.

I think I should tell you that as of March 30, 80 per cent of the doctors in Michigan have signed the new Provider Agreement. There are 7,293 who signed the Agreement out of 9,338, which is very good—in fact, as good as any state and probably better than most.

The telephones of all committee members, as you can imagine, were kept pretty busy during those hectic five weeks when we were trying to get the Provider Agreement signed. Then, when we finally got that off the table, we approached the printed form—that sort of sickish pink, small lettered, small spaced, 108 question thing that gave a headache to you and your office girls.

The committee spent most of its time trying to alter the Provider Agreement, and we have devised a short form. It should be in your office this week. We have them with your name on them for the meeting this afternoon, and at that time if there is any discussion in relation to the short form itself I will be happy to take it up with you.

It outlines in heavy ink those questions which are mandatory for reimbursement. It reduces the number of questions for which answers are required; I think there are only fourteen now. It provides a number of questions that are optional and can be used in unusual circumstances or cases where individual consideration is required.

The single item on the invoice form that we failed completely to move is No. 26, which is the diagnostic code. However, we did alter No. 25, which has influence on No. 26, and the Social Services Department will help us with the most frequently used procedures done by individual doctors, so that I think the problem of No. 26 will be largely overcome. This can also be discussed this afternoon.

Other problems and their solutions which the committee addressed itself to were mostly bureaucratic, red-tape problems, if you will. We simply made the doctors' feelings known. The government responded by removing the log jam—things like reimbursement for newborn Medicaid-eligible children who had not yet been enrolled as recipients. Coverage for emergency medical service, which at first was totally refused and now has been resolved to some degree. We will talk more about that this afternoon.

Psychiatric services for outpatients are now included as a benefit for Medicaid.

We clarified that physicians do not have to wait for payment by Medicaid, Blue Shield or other payors before billing for Medicaid coverage. Doctors can bill Medicaid immediately upon delivery of services to a patient who may have other third-party coverage, and collect for it on that simple basis.

We informed the Social Services Department of the doctors' unrest over the dogmatic attitudes exhibited in the first seminars on how to fill out invoice forms given to our office girls. I think we now have a direct input into these seminars that will make them of more value and a greater learning experience for our girls. The department has set up another series of these lectures, and we urge you to have your office help attend them. It will be good experience for them.

Perhaps most important besides all of these small things, we have developed a strong and honest dialogue with the Department of Social Services, with the Executive Office, and with Dr. Donald Smith in his role as Director of the Governor's Office on Health and Medical Affairs, who I think I can say is our real friend.

We as the Michigan State Medical Society have ready access to many of these offices for quick and effective results, that we did not have before, and I suspect they will probably become the physician's best advocate in dealing with the state government.

We reported to the Governor both by letter and verbally, and told him pretty much that Michigan doctors were not satisfied with the Medicaid program as it exists today, and that he must be aware that further improvements are required to maintain a good relationship between the medical practitioners and the State itself.

Finally, I would like to say a word about the committee. We started in crisis. Our charge was perhaps different from anybody else's. Medicaid was a mess. Fix it. The program couldn't work without doctors. Make it operable. So, there we were. We simply tried to do it. What happened to this Committee that has never happened to another committee I have ever been on was that they gave us leeway. They let us think and make decisions. They let us bargain. I think in large part that latitude given the committee was what allowed us to move forward and cross over without having to report back on every single detail. I would suggest that this might be a form of committee in the future for not just crisis but for things particularly when you have to deal with a government agency or something that moves slowly.

Finally, the committee met and decided that they had fulfilled their obligation to the House, and asked that they be dissolved. However, it was asked by Dr. Smith and suggested by our own leadership that a continuing liaison committee for Medicaid's problems be instituted, and I think this will happen.

Mr. Speaker, in reporting this there are a lot of things I would like to say, but I think we will save them for this afternoon when the members bring up questions. Let me say just one thing. We told the people, "If you are going to take this over and do it, you have got to do it better than it was done before." So, the hurry-up part of the payment was part of the deal we asked for. The Social Services Department is now paying us 75 per cent of the 1971 figures, and as of July they will go to the 1972 data collection figures.

There are no profiles involved. As of March 1 all invoices received by March 1 that were true invoices were paid by March 30, and the goal is to have it in 14 days. I brought for this afternoon's session a small item that shows you from the time your invoice hits the office what happens to it, and how you should be paid in 14 days. This is the goal they are shooting at. They have accomplished half of it. We haven't got as nice pictures as Vern had for demonstration purposes. I figured a good secretary typing it up would be fine, but we do have illustrative things for you at the meeting this afternoon. I urge you to complete your golf game before four-thirty.

11. Report of the Committee on Planning & Priorities—Stuart M. Gould, Jr., MD, Chairman

(In the absence of Dr. Gould, the report was read by Marjorie Peebles Meyers, MD)

The Committee in its report to The MSMS Council and House of Delegates in the fall of 1972 indicated that it was planning to make a comprehensive report to the 1973 fall session but would make an interim report in the spring of 1973.

The committee has continued to meet on a regular basis and feels that its work is on schedule.

The committee in this report will review briefly its work to date and will offer a series of recommendations dealing with (1) MSMS purposes, and (2) MSMS objectives.

For consideration this fall, the committee will report on (1) possible changes in structure, (2) member services, (3) committees, (4) responsibilities to the public, and (5) priorities.

Work To Date

The Planning and Priorities Committee was organized in January 1972 to include broad geographic representation from the general membership, the House of Delegates, specialties, medical students, and so on. The Council suggested that there was a need to study priorities for MSMS activities and to consider the possible duplication of committee work. The Alexander Grant Company analysis of the membership opinion survey was sent to members of the MSMS House of Delegates prior to the 1972 spring meeting. The spring House decided the Planning and Priorities Committee also should consider the recommendations in that report about membership services, structure, etc.

The Committee progress report to the 1972 fall meeting of the House of Delegates described in some detail the work of the Committee since the Spring session.

A subcommittee studied the opinion poll comments about membership services and our full committee adopted recommendations of a preliminary nature. These will be reviewed again and presented formally to the 1973 fall session.

Since the 1972 spring House meeting, our Committee has developed four alternative models for possible changes in MSMS structure and relationships with components and members. In putting together the various models, committee members were impressed to find an almost infinite number of combinations that might strengthen MSMS. Committee members believe that action by The MSMS Council and House of Delegates this spring on recommendations about MSMS purposes and objectives will permit the Committee to review and finalize its thoughts about possible improvements in structure.

The Committee has been enlarged since last fall. New members of the Committee are Dean Carron, MD, immediate past president of the Washtenaw County Medical Society; Homer Smathers, MD, immediate past president of the Wayne County Medical Society, and Frederick Sabin, MD, Marquette.

Committee members often have remarked that changes should not be proposed merely for the sake of change. We are sincerely interested in eliminating possible duplication, in refining and updating our purposes and objectives, and in making the overall society more effective to serve both the profession and the public.

Committee members are able and eager to visit component medical societies to discuss problems and possible solutions and to listen to reactions. Such meetings would facilitate the work of the Committee as it finalizes its report for the fall meeting of the House of Delegates.

Proposed Changes in MSMS Purposes

The Committee had discussed the MSMS purposes as stated in the Constitution and Bylaws many times, and then spent considerable time at both the Feb. 7, 1973 and March 21, 1973 meetings on the subject. There was general agreement that the present purposes, which were revised and updated by the House of Delegates in 1971, are quite accurate today. Some minor changes in wording were recommended. The Committee recommends that several new statements be added either to put in writing some purposes that MSMS indeed does seek to accomplish or to add some new purposes that would be appropriate because of changing conditions.

The Committee agrees that the first purpose in the present constitution is the general, over-all foundation for MSMS, and should be given paramount focus and attention. The other suggested purposes support and complement the first central purpose.

Probably the best way to compare the present statements of purpose with those recommended by the Committee would be to study the present Constitution first, and then evaluate the relatively minor changes and additions in the proposed list.

The purposes in the present MSMS Constitution are stated as follows:

(1) To bring into one viable, effective organization the ethical physicians, licensed to practice in Michigan, in order that their contribution to human welfare will be enhanced.

(2) To constitute, support and assist the American Medical Association in cooperation with similar societies of other states, in meetings its appropriate responsibilities and, in like fashion, to form constituent and component medical societies.

(3) To conceive, develop and administer health education programs designed to improve public understanding, awareness and acceptance of good medical standards, practices and concepts, as they relate to personal health, scientific progress and society's advancement.

(4) To stimulate advancement of the science and art of medicine, and continually to seek to advance the medical, scientific, social, environmental, economic and medical political knowledge of its members in order that the doctor may better serve his patients and the public health generally.

(5) To aid Michigan physicians individually and collectively in maintaining high levels of ethical conduct and standards of practice to protect and serve the total public.

(6) To work with other medical and nonmedical groups and persons through individual members and as a corporate body toward stimulating progress in all aspects of health care in Michigan and elsewhere, thereby offering leadership toward meeting the health needs of the people.

(7) To preserve voluntary medical practice, recognizing it as a most effective means of delivering quality health care.

(8) To develop methods, techniques and practices that moderate the costs of quality medical and health care and provide for fair remuneration for services rendered.

(9) To ensure the future of medical practice by attracting capable people into the medical and health professions

and help arrange for the most effective distribution of their services.

(10) To encourage medical students and physicians-in-training to participate in, understand, and help develop the purposes and goals of organized medicine in order that the total objectives of the profession be enhanced and accomplished.

(11) To combat the efforts of all those who would denigrate the reputation and services of the medical profession.

(12) To carry on such functions and activities as are deemed necessary or desirable to accomplish effectively the above purposes; provided, however, that the Society shall engage in no activities which cannot be construed as relevant, incidental, or necessary to its charitable, educational, or scientific purposes.

Following are the proposed purposes as recommended by this Committee:

TO BRING INTO ONE VIABLE, EFFECTIVE ORGANIZATION THE ETHICAL PHYSICIANS LICENSED TO PRACTICE IN MICHIGAN, IN ORDER THAT THEIR CONTRIBUTION TO HUMAN WELFARE WILL BE ENHANCED.

In order to effectively accomplish this, MSMS also will work to accomplish the following sub-purposes:

A. To constitute, support and advise the American Medical Association in cooperation with similar societies of other states, in meeting its appropriate responsibilities.

B. To charter and organize constituent component medical societies.

C. To conceive, develop and administer health education programs designed to improve public understanding, awareness and acceptance of good medical standards, practices and concepts, as they relate to personal health, scientific progress and society's advancement.

D. To stimulate advancement of the science and art of medicine and continually to seek to advance the medical, scientific, social, environment, economic and medical political knowledge of its members in order that the doctor may better serve his patients and the public health generally.

E. To aid Michigan physicians individually and collectively in maintaining high levels of ethical conduct and standards of practice to protect and serve the total public.

F. To provide medical leadership in meeting the health needs of the people by working with other medical and nonmedical groups and individuals.

G. To enhance physician-patient relationships, as basic to the delivery of quality health care.

H. To promote quality medical and health care by development and support of activities appropriate to this goal.

I. To advocate fair remuneration for services rendered.

J. To ensure the adequacy of medical manpower by attracting capable people into the medical and health professions and to work toward the most effective distribution of their services.

K. To encourage medical students and physicians-in-training to participate in organized medicine in order to enable MSMS to be representative of all physicians.

L. To support the efforts of those who would enhance the reputation and services of the medical profession.

M. To institute and provide specific services to meet the needs of the members.

N. To foster and support continuing medical education.

As explanation of the proposed changes, it can be noted that the present purposes as stated on pages 2 and 3 . . .

(1) Remains as the first, over-all purpose.
(2) Divided into (A) and (B) on the proposed list.
(3) Remains word for word as (C)
(4) Remains the same as (D)
(5) Remains the same as (E)
(6) Shortened and restated as (F)
(7) Rephrased as (G)
(8) Divided into (H) and (I)
(9) Rephrased as (J)
(10) Shortened as (K)
(11) Rephrased as a positive statement, as (L)
(12) Omitted. The content generally is covered in the first, over-all purpose.

On the proposed list of purposes (M) and (N) are new. These two purposes put into writing goals and activities that have been observed by MSMS for many years.

Recommended MSMS Objectives

The Committee, when it studied purposes, objectives and activities, facilitated its discussion and decisions by using the following definition of terms:

"Purpose"—the reason why we exist as an organization; broad and general.
"Objective"—a specific goal that can be reached and success measured; can be both short term and long-range.
"Activities"—work load of projects and efforts to reach the objectives.

Using these definitions, the Committee reviewed the "Council Objectives" that were developed by Council members in December. It was decided that some of those projects really were activities rather than objectives. The Committee members added other objectives and changed the wording of some of those on the Council list.

Committee members agreed that any list of MSMS objectives should spell out MSMS efforts (1) to serve MSMS members, (2) to serve the patients, and (3) to serve the public.

The Committee members then tried to sort the objectives into a list of current objectives and a list of those that are viewed as areas that MSMS should move into.

The Committee recommends that The MSMS Council and House of Delegates should support and implement the work towards the following *Current Objectives*:

(1) Seek solution to Medicaid problems.
(2) Monitor and coordinate development of PSROs in Michigan.
(3) Create medical care guidelines for adoption by regional PSROs.
(4) Develop and support MSMS policies re current legislation.
(5) Introduce legislative measures to alleviate professional liability insurance problems.
(6) Initiate a more effective informal liaison with Michigan Medical Service.
(7) Continue efforts by MSMS officers, Councilors and staff members to visit each component medical society.
(8) Continue new efforts to improve and increase MSMS working relationships with the medical specialty societies and the Council of Specialty Societies.
(9) Increase assistance to components in membership retention and recruitment.

The Committee further recommends that The Council and House identify the following objectives as *Intermediate Objectives* and proceed to work in these areas.

(1) Develop continuing medical education certification plan for Michigan.
(2) Begin efforts to involve MSMS in MD placement activities.
(3) Carry forward the five present MSMS public relations projects, which are VD Education, Education about the Medical Aspects of Pollution, Chiropractic Education, Work to Make Medical Assistants More Effective Communicators, and Help People Find a Doctor, and

to especially concentrate on projects to educate both the physician and the public about chiropractic.

(4) Conduct and evaluate MSMS sponsored practice management seminar on a pilot basis.

(5) Conduct several opinion surveys of MSMS membershop on important issues.

(6) Study the trends of utilization of emergency rooms and recommend appropriate MSMS involvement.

(7) To continue to improve techniques and methods of communicating with the members and the public; and to encourage communication from the members to MSMS.

(8) Coordinate and enlarge the negotiating activities in the broadest sense.

(9) Develop program of member assistance.

(10) Encourage and assist component medical societies so they can take active roles in community health related programs such as area-wide planning.

(11) Explore and determine the proper MSMS role in matters of state and federal funding of medical and health services.

(12) Develop concepts and models of ambulatory care systems so physicians can provide leadership in this matter.

* * *

After the House has acted to approve the current and intermediate objectives, the Planning and Priorities Committee plans to advise and counsel The Council in determining priorities.

The Committee points out to the House of Delegates especially that its action on objectives should *not* be limiting because The Council will have to adopt immediate and short-range objectives from time to time as new opportunities to serve are identified within policy framework adopted by the House.

The Council and House should have the opportunity each year to review the current objectives and the intermediate objectives in order to keep the organization timely and relevant.

In closing this interim progress report, the members of the Planning and Priorities Committee want to thank MSMS officers, councilors, chairmen, component society officers, specialty society leaders, and MSMS staff members for their assistance and advice in the work done to date. The entire project has been an interesting challenge and the Committee is eager to continue its deliberations.

REFERENCE COMMITTEE ON CONSTITUTION & BYLAWS, David Millard, MD, Acting Chairman, recommended the following amendments:

> **Item G should be amended to read: "To preserve, protect and enhance physician-patient relationships, as basic to the delivery of quality health care."**
>
> **Item L should be amended to read: "To support the efforts of those who would preserve, protect and enhance the reputation and services of the medical profession."**

THE HOUSE accepted the proposed purposes, as amended. The Constitutional amendment to effect the changes will be presented on first reading at the Annual Session of the House this fall as required by Article XIII.

REFERENCE COMMITTEE D, Harold F. Falls, MD, Chairman, recommended acceptance of the MSMS objectives as expressed in this Committee report.

THE HOUSE accepted the objectives as recommended by the Reference Committee.

12. Report of the MSMS Ad Hoc Committee to Implement Resolution 54 of the 1971 House of Delegates—George Koepke, MD, Chairman

(The following report was presented in written form.)

The 1971 MSMS House of Delegates approved Resolution 54 about the "Emigration of Medical Graduates." (See Addendum A for the actual resolution)

The Speaker of the MSMS House was authorized to appoint an ad hoc committee to study the matter and present "specific recommendations to help minimize this loss."

The Speaker asked the Education Liaison Committee and the Liaison Committee with Medical Students to join as the ad hoc committee because the two groups met the special committee composition spelled out by the MSMS House resolution.

The Committee conferred several times with the three medical school deans and their representatives. The deans likewise are concerned about the matter and have authorized a cooperative research project. The deans and others have pointed out that it is not proper to contend that many graduates of the three Michigan medical schools leave the state based only on the reports of where they go for their internship training. Certainly some of them return to Michigan for their residency training and/or their actual practice. Exact figures are not available so the deans' research efforts are being continued. The research also will follow the graduates of other medical schools who come into Michigan for their internships and residencies, and the movement, too, of foreign-trained physicians. The research also will follow Michigan young people who go to medical schools in other states.

The conclusion drawn in the resolution that too many graduates of the Michigan medical schools leave Michigan is only part of a more complex subject. Broadly speaking, the resolution raises questions about the movement of graduates, but also about the composition of the physician manpower pool. A detailed analysis is needed and is being undertaken cooperatively by the three medical schools. Information will be studied about the parent's residence, place of high school graduation, place of undergraduate education, marital status, wife's previous address, etc.

Such information should be obtained also about the new physicians who begin actual practice each year in Michigan.

In recent years the number of new physicians coming to Michigan, but educated and trained elsewhere, tends to equal the number of Michigan medical school graduates who go elsewhere.

Efforts should be made to keep more of our Michigan graduates, but any legislation that would deter the movement of out-of-state doctors to Michigan would be undesirable and unfortunate.

The available figures for 1971 show that of 2,380 doctors in training in Michigan hospitals, 616 were from out-of-state schools and 571 from U-M and WSU, while 1,193 were from foreign schools. 1972 figures are not available.

The statistics also show that of the 8,641 physicians in practice in 1971, 3,702 were graduates of U-M and WSU, 4,132 were graduates of other U.S. schools. Another 807 were graduates of foreign schools.

Of the American-educated physicians in training in Michigan, 24.3% are from the U-M and WSU and 25.8% are from other U.S. schools. Together these figures account for 50.1% of all the physicians in training in Michigan as compared to 49.9% being from foreign medical schools.

These figures were developed by the office of Medical Center Planning of the University of Michigan. The data was obtained from the Medical Mailing Service, a contractor for the AMA.

A study made by the MSMS Bureau of Economic Information found that of the 1,286 MDs who received Michigan licenses between July 1, 1969 and July 1, 1971, 40.5% were from U-M and WSU, 38.8% from other U.S. schools and 20.7% were foreign graduates.

Addendum B shows the internship decisions made in 1971, 1972 and 1973 by graduates of the Michigan schools.

A related factor in this study and proposed solutions is the fact that the internship, as it has been known generally, will soon be discontinued. Some specialties have decided not to include new medical school graduates immediately in their established residency programs so the first year of training after graduation will be changed.

Recommendations made in this report should be reviewed and updated periodically.

Former decisions and new decisions by a number of organizations have a direct bearing on this complex subject. These groups include the Council on Medical Education and the House of Delegates of the American Medical Association, the Association of American Medical Colleges, the Liaison Committee on Medical Education of the AMA and AAMC, the administrative board of the Council of Teaching Hospitals, NIRMP, the state medical licensing boards, and others. In Michigan, the groups include MSMS, the three medical schools, hospitals, Michigan Association for Medical Education, the State Board of Registration in Medicine, the legislature, etc.

The ad hoc committee named to implement the 1971 resolution made a progress report to the 1972 fall House meeting and promised that recommendations would be made to the 1973 spring meeting.

Recommendations

The following recommendations are not ranked in any special order of importance.

Recommendation 1: MSMS should encourage Michigan hospitals with intern and resident training programs to continue all efforts to make their teaching programs effective and rewarding.

Background: No one will dispute the relationships between the quality of the hospital teaching program and the decisions made by young physicians to select certain hospital and specialty programs over some others. Quality can not be discounted.

Recommendation 2: The MSMS Council should continue its study of a possible proposal to the Michigan legislature requesting state appropriations for postgraduate training programs for interns and residents.

Background: Alternative methods of financing postgraduate training are being sought in Michigan and other states. There is support in various circles in Michigan for a program in operation in Indiana where the legislature does fund intern and resident programs. Reports from Indiana indicate the program is a factor in retaining more Indiana graduates in Indiana.

State appropriations, it is believed, would enable teaching hospitals to expand and improve their teaching programs. Such quality improvement should help Michigan training programs to interest more Michigan graduates—and graduates of other U.S. schools.

Recommendation 3: MSMS should allocate funds or seek a special grant in order to conduct research to determine why Michigan medical students do or do not take their internship or residency in Michigan.

Background: There is little available data to help this ad hoc committee of future MSMS committees to study this complex subject and offer recommendations based on interviews, opionnaires, etc.

This ad hoc committee and the deans' research committee has proof that statistics do not exist as a basis for forecasts, etc. The committee has no preconceived ideas about what kind of research is needed, but random sample interviews could produce helpful data about attitudes, opinions, etc., that cannot be obtained by merely comparing figures.

If approved, this recommendation should be assigned to some ad hoc committee to decide on the kind of research, etc.

Recommendation 4: MSMS should continue its summer placement program for students of the three medical schools. (This program is known as the Student American Medical Association—Medical Education Community Orientation.)

Background: The MSMS Council in 1970 approved as a pilot project an MSMS effort to place medical school students in community hospitals to learn firsthand more about the work of the doctor and the operation of the hospitals. Eleven students were placed in 7 hospitals. The project since has been administered by the MSMS Department of Communications. In 1971, fifty-one students were placed in twenty-three hospitals; in 1972, ninety-two students were placed in fifty-six hospitals.

This coming summer, one hundred and five students from the three schools will observe and learn at fifty-two hospitals.

The reactions from the students, the volunteer MD coordinators, the hospital administrators and the three medical schools have been positive.

The project involves the medical student early in his or her medical school course and likely provides new experiences while he or she is consciously or unconsciously making decisions that will affect life after graduation.

MSMS will research the SAMA-MECO follow-up aspects. There are encouraging signs. For example, two WSU juniors spent the summer of 1971 in Muskegon in a SAMA-MECO experience and now are interning in Michigan. Both do plan to practice in or near Muskegon.

Recommendation 5: MSMS should compliment the three medical schools and cooperate in the new preceptorship-type programs now being conducted to give students off-campus, person-to-person experiences with family physicians, internists and pediatricians.

Background: The medical schools in 1972 received a federal grant to establish a coordinated, cooperative program of primary care or family practice preceptorships. While the program is very new, ad hoc committee members feel such a program will help retain more graduates of the three schools in Michigan.

MSMS is encouraging interested, qualified physicians to serve as preceptors in this new project.

Recommendation 6: MSMS should encourage and assist the Michigan chapters of national specialty societies to explore and conduct projects that will provide more person-to-person, first-hand experiences and relationships with medical students at the three Michigan schools.

Background: The ad hoc committee compliments the Michigan Academy of Family Physicians for the "Future Family Practice Clubs" operating in Detroit, Ann Arbor and East Lansing and cites this project as one way to accomplish the intent of this recommendation. Leaders of the MAFP report that the clubs and the volunteer MD leaders are providing information and inspiration to medical students considering possible careers in family practice. Some of these former students have moved into family practice residency programs at Michigan hospitals.

Recommendation 7: MSMS should encourage the component medical societies in the counties with teaching hospitals to work closely with the directors of medical education, hospital administrators, etc., to find new ways to recruit more effectively the graduates of the three Michigan schools.

Background: The ad hoc committee is not aware of many closely coordinated efforts of the component medical society and the teaching hospitals in intern and resident recruitment projects. The pilot programs in some areas should be shared.

New ways should be explored to involve the local chamber of commerce, banks, auto dealers, realtors, etc., to help recruit medical school graduates and to help them get established when they arrive.

In several cases (the Genesee County Medical Society Auxiliary, for example) the woman's auxiliary can be helpful. The auxiliary especially could help find good ways to interest the wives of married students.

The ad hoc committee members feel that involvement by the medical society in recruitment of interns and residents could help later to encourage these young doctors to join the component societies, MSMS and the AMA.

Recommendation 8: The MSMS Council should appoint an ad hoc committee to explore ways to make financial assistance available to Michigan medical school students needing such help.

Background: The available financial help at the three medical schools is being strapped now because federal funds for loans and grants have been reduced, because the three schools have more disadvantaged students enrolled and because costs of education and costs of living have increased. Some students do obtain help from component medical societies. Some borrow from the AMA-ERF guaranteed loan program which requires interest payments each year even while the person is in school.

The ad hoc committee has studied possible new programs several times with MSMS treasurer John Ylvisaker, MD, and members feel various ideas should be explored more vigorously by an ad hoc committee that should include Doctor Ylvisaker.

The committee compliments the Muskegon County Medical Society and interested Muskegon doctors who in 1971 began a program to help students through medical school on an arrangement that Muskegon hopes will bring these young doctors to Muskegon to practice. Other county societies and communities are encouraged to explore such ideas.

The ad hoc committee members feel that the concerns expressed by MSMS and component societies, and the actual financial help provided, can be at least an indirect factor later when the student decides where to intern, or take his residency or where to practice.

Recommendation 9: MSMS should encourage the deans of the three medical schools to develop ways that the medical school faculty members can know more about the training opportunities offered by Michigan hospitals so the faculty members can effectively counsel the seniors about postgraduate opportunities in Michigan.

Background: MSMS, on this project, could suggest that MAME present a program or seminar on the campus of each medical school in order for these directors of medical education to explain their programs and to answer questions. This is a basic step so the teachers can guide and assist students about programs at Michigan hospitals.

This recommendation is made because several research studies show that members of medical school faculties do have both a direct and indirect influence on student internship decisions.

Recommendation 10: MSMS should cooperate with other interested groups or should take the leadership to develop and publish composite information about the graduate medical education opportunities in Michigan for distribution to students in the three Michigan medical schools and to others who would consider further training and possible future practice in Michigan.

Background: This project was proposed in 1971 by the hospital directors of medical education, and has been discussed by representatives of MSMS, the hospital association, the Michigan Health Council, Michigan Blue Shield and Blue Cross and other interested groups.

Supporters of the project contend that such a master composite publication is needed and would be valuable.

The ad hoc committee would respectfully suggest that the MSMS Publication Committee consider publishing this material in *Michigan Medicine* for all physicians, and provide reprints for students, interns, etc. The committee has no preconceived ideas about the content or format for the copy. Perhaps a set of suggested subject areas could be developed for each hospital or residency program to follow.

Recommendation 11: MSMS should operate the MD Placement Service in Michigan so MSMS can help component societies and communities recruit doctors for Michigan and so medical students, new graduates, those completing internships, and residencies, etc., will look to MSMS for help in locating in Michigan.

Background: Only in Michigan and West Virginia do the state medical societies *not* operate the MD Placement Service for that state. In Michigan, MSMS sponsored the formation of the Michigan Health Council more than 25 years ago and the Health Council operates the MD Placement Service. This recommendation is in no way intended to criticize the Health Council Placement Program, but the ad hoc committee members feel MSMS is in a better position to work effectively with the component societies in MD recruitment activities. The committee believes that the doctor who comes to Michigan partly as the result of MSMS services would be more apt to join the component society and MSMS than at present. Now he gets no letters, no service from MSMS.

By operating the MD Placement Service, medical students, graduates, interns, residents, returning servicemen, etc., would all learn more about the work of MSMS in other areas.

MSMS would be able to build stronger ties for the community and component society to the graduating senior or newly-licensed doctor than can the Health Council. The MSMS Councilors and staff members can facilitate this work as part of the expanding ongoing liaison work.

Recommendation 12: MSMS should compile each year the names and mailing addresses of those graduates from the three Michigan medical schools who leave the state for internships, military service, etc., and should send them occasional materials and appeals that they return to Michigan for their residency training and/or for their practice.

Background: Some new graduates decide to go out of state for their internships, but intend to come back later. This decision should be encouraged and active contact should be maintained.

An MSMS placement service would complement this contact work.

Component societies and MSMS should benefit as these young men return with a good feeling about the interest shown by MSMS. Likely they will be more eager to join the component society, MSMS and the AMA. At present there is no organized contact system in operation.

Recommendation 13: MSMS should continue to distribute *Medigram* to the students of the three schools.

Background: The MSMS *Medigram* newsletter will help the Michigan students learn more about the concerns and efforts of Michigan physicians to serve the public and the profession. This is a complementing type of activity to other more direct keep-'em-in-Michigan projects.

Recommendation 14: MSMS should encourage component medical societies to establish and maintain contact with students from their counties who are in pre-med programs or in medical schools. Some counties could be encouraged to experiment with a big-brother approach by matching some interested physician with each of these students. Components could mail their bulletins, could send medical reference books as occasional gifts, could invite students to local meetings during holidays, etc. The possibilities of such component projects should be encouraged.

Background: Such activity could be an indirect reason why a medical graduate might practice later in Michigan.

Addendum A to Report to H/D re Resolution 54

RESOLUTION 54/1971

Emigration of Medical Graduates
George G. Stilwill, MD, Ingham County

Referred to: Public & Professional Relations
(Robert E. Rice, MD, Chairman)

House Action: Adopted

Whereas, large percentages of graduates of the University of Michigan, Wayne State University, and Michigan State

University leave the state for purposes of internship, residency training, and for the practice of medicine, and

Whereas, the people of the State of Michigan have had a commitment of resources in their undergraduate training, and

Whereas, the members of the MSMS are concerned that the citizens of Michigan continue to receive the best medical care possible, be it

RESOLVED: That the House of Delegates authorize the Speaker to appoint an ad hoc committee composed of academic and practicing physicians, and medical students to investigate the causes of this loss to the people of the State of Michigan, and be it further

RESOLVED: That the committee submit a series of specific recommendations to help minimize this loss. This report should be presented to The Council and 1972 House of Delegates.

Addendum B to Report to H/D re Resolution 54

Internship Choices of Michigan Medical School Graduates

1971	Remaining in Michigan	Leaving Michigan	Total
University of Michigan	83 (41.1%)	119 (58.9%)	202
Wayne State University	60 (42.6%)	81 (57.4%)	141
1972			
University of Michigan	82 (45.3%)	99 (54.7%)	181
Wayne State University	77 (61.1%)	49 (38.9%)	126
Michigan State University	15 (50.0%)	15 (50.0%)	30
1973			
University of Michigan	78 (42.2%)	107 (57.8%)	185
Wayne State University	84 (69.4%)	37 (30.6%)	121
Michigan State University	13 (39.3%)	20 (60.7%)	33

REFERENCE COMMITTEE B, Richard C. Deming, MD, Chairman, recommended adoption of the recommendations, but suggested a minor change in Recommendation 9, changing "postgraduate opportunities in Michigan" to read "graduate opportunities in Michigan," and a substitute for Recommendation 11 as follows:

> "That The MSMS Council appoint an ad hoc committee to confer with Michigan Health Council regarding future operation of the MD Placement Service for Michigan, and to report to the fall meeting of the House of Delegates."

THE HOUSE adopted the report of the Reference Committee.

13. Report of the Committee on Constitution and Bylaws—Stuart M. Gould, MD, Chairman

PART I

The following proposed Bylaws changes were passed on first reading by the Fall 1972 House of Delegates and are herewith presented for final consideration:

Reference Committees of the House of Delegates

In order to conform to present practices, the Committee recommends that Chapter 9—House of Delegates, Sec. 9—Reference Committees be amended to read:

"Sec. 9. *Reference Committees.* The House of Delegates shall have the following reference committees, together with tellers and sergeant-at-arms, appointed by the Speaker of the House, and such other reference committees as the Speaker may deem necessary to conduct the business of the House:

1. Credentials.
2. Rules and Order of Business.
3. Constitution and Bylaws (which shall serve also as the standing committee on Constitution and Bylaws).
4. Ways and Means."

RECOMMENDATION: That this Bylaws amendment be adopted on second reading.

Membership

The current provision for refund of dues due to death or expulsion is cumbersome. A survey of other state medical associations shows that none have this provision.

The refund complicates the estate since it has already been declared a tax deduction and the amount of money involved is insignificant.

Therefore we recommend that Chapter 4, Sec. 4, which provides for refunds for death or expulsion, be deleted.

RECOMMENDATION: That this Bylaws amendment be adopted on second reading.

Reference Committees of The Council

During past years The Council has made, with the permission of the House, some changes in The Council reference committee system. It was agreed that this would be done on a trial basis and that, if it proved successful, Bylaws changes would be recommended to make these changes permanent.

Therefore the Committee recommends the following amendments to reflect these changes:

1. Amend the last sentence of Chapter 10, Sec. 1, to read: "At its first meeting following the Annual Session of the House of Delegates, it shall elect a Chairman, a Vice-Chairman, a Chairman of the Finance Committee, a Chairman of the Scientific and Educational Affairs Committee, and a Chairman of the Legislative Policy Committee, who shall be duly elected Councilors, each to take office immediately and to serve for a term of one year or until his successor is elected and takes office."
2. Amend Chapter 10, Sec. 2, to read: "Sec. 2. EXECUTIVE COMMITTEE—The Executive Committee of The Council shall consist of the President, the President-Elect, the Speaker of the House of Delegates, the Vice-Speaker of the House of Delegates, the Chairman of The Council, the Vice-Chairman of The Council, the Secretary, the Treasurer, the Chairman of the Finance Committee, the Chairman of the Scientific and Educational Affairs Committee, and the Chairman of the Legislative Policy Committee. The Chairman of The Council shall serve as Chairman of the Executive Committee."
3. Amend Chapter 10, Sec. 3, to read: "Sec. 3. REFERENCE COMMITTEES—The Reference Committees of The Council and their composition and duties shall be as follows:
    - (a) The Scientific and Educational Affairs Committee shall consist of a Chairman elected by The Council as provided above and members appointed by the Chairman of The Council with the advice and approval of The Council. The Scientific and Educational Affairs Committee shall advise The Council on matters of scientific and educational activity and relationships with component medical societies, and consider other matters referred to it by The Council.
    - (b) The Finance Committee shall consist of a Chairman

elected by The Council as provided above and members, of which one shall be the Treasurer, ex officio, with power to vote, and the remainder appointed by the Chairman of The Council with the advice and approval of The Council. The Finance Committee shall advise The Council on administration of the Society's finances, and consider other matters referred to it by The Council.

(c) The Legislative Policy Committee shall consist of a Chairman elected by The Council as provided above and members appointed by the Chairman of The Council with the advice and approval of The Council. The Legislative Policy Committee shall advise The Council on matters of legislation and liaison with governmental agencies and shall consider other matters referred to it by The Council."

Sections (d) and (e) of Sec. 3 are to be deleted.

4. Amend Sec. 4, Chapter 10, to read: "Sec. 4. SPECIAL AND AD HOC COMMITTEES—The following committees shall be appointed by The Council or its Chairman, with the advice and approval of The Council:

(a) The Publication Committee shall serve as the Editorial Board of the Journal of the Michigan State Medical Society and shall advise The Council and the Executive Editor in the conduct and policy of the Journal. The Scientific Editor shall be an ex officio member of this Committee, without power to vote.

(b) The Education Liaison Committee shall consist of a Chairman, and not more than seven members. The deans of the medical schools of Michigan and the Secretary of the Michigan State Board of Registration in medicine shall be advisory members of this committee without power to vote. The Education Liaison Committee shall advise The Council on matters pertaining to undergraduate medical education.

(c) Such additional special ad hoc committees may be appointed as may be required to administer efficiently the functions and duties of The Council, provided that no existing standing or special committee is qualified to perform such duties. Each such committee shall be required to render periodic reports to The Council of its activities, findings and recommendations."

RECOMMENDATION: That these Bylaws amendments be adopted on second reading.

PART II

The following are recommendations of the Committee for changes in the Constitution and Bylaws to be considered on first reading, and, if adopted, laid over to the next session of the House for final consideration:

1. *Section on Clinical Pharmacology and Therapeutics*

RECOMMENDATION: That Chapter 14, Sec. 1, of the MSMS Bylaws, be amended by adding to the list of sections "Clinical Pharmacology and Therapeutics."

COMMENT: The Committee considered a request to establish such a section to conform with a similar AMA section and believes it to be appropriate.

2. *Separate Gratiot and Isabella-Clare County Medical Societies*

RECOMMENDATION:

(1) That Chapter 10, Sec. 9, be amended to change listing for the Eighth District as follows: ~~"Gratiot-Isabella-Clare,~~ GRATIOT, ISABELLA-CLARE, Midland, Saginaw, Tuscola."

(2) That Chapter 11, Section 2, be amended to change listing for District #4 as follows: "Bay-Arenac-Iosco, Genesee, Gratiot, Huron, Isabella-Clare, Lapeer, Midland, Saginaw, Sanilac, Tuscola."

COMMENT: This will effect the change authorized by the House of Delegates in October, 1972, separating Gratiot-Isabella-Clare into two societies.

3. *Revisions in Chapter 11—Judicial Commission*

RECOMMENDATION:

(1) Amend Constitution, Article XI—JUDICIAL COMMISSION, second sentence, as follows: "It shall consist of members to be elected by the voting members of the Society~~, provided, however, that the members of the first Judicial Commission established hereunder shall be selected in such manner as may be provided by the Bylaws to serve until their respective successors are elected.~~

(2) Amend Bylaws Chapter 11, Sec. 3, as follows: "Sec. 3. NOMINATIONS—~~On or before September 25th in the year 1965 and on~~ or before July 15th ~~in~~ each ~~succeeding~~ year, the Chairman of The Council shall, with the advice and consent of The Council, appoint a Nominating Committee composed of seven members of The Council. Such Nominating Committee shall select from the voting members in good standing of the Society in each Judicial District at least twice as many nominees for the office of Judicial Commissioner as are to be elected in such year from such district. After obtaining the consent of such nominees to become candidates, the Nominating Committee shall submit its list of nominations to the Secretary of the Society ~~on or before October 15th in the year 1965 and~~ on or before September 1st ~~in each succeeding year.~~ Within ten days thereafter, the Secretary of the Society shall post a list of such nominations in a conspicuous place in the headquarters building of the Society and shall mail a list of such nominations to the secretary of each said component county society and shall give notice to the secretary of each said component county society that the voting members of this Society within the several Judicial Districts have the right to make additional nominations by petition as hereinafter set forth. Promptly upon receipt of such notice and list of nominations the secretary of each component county society shall make such nominations known to the voting members thereof in such manner as shall be determined by the component county society. Additional nominations may be made by petition signed by not less than twenty-five voting members in good standing in any Judicial District. Such nominating petitions shall be filed with the Secretary of this Society ~~not later than November 25th in the year 1965 and~~ not later than October 15th ~~in each succeeding year~~.

(3) Amend Chapter 11, Sec. 4, as follows: Sec. 4. BALLOT-ELECTION—Under the direction of the Secretary of the Society, separate ballots, in such form as shall not identify the voter, shall be prepared for each Judicial District from which a member of the Commission is to be elected. On or before ~~December 15th in the year 1965 and on or before~~ November 10th ~~in~~ each ~~succeeding~~ year in which a member of the Commission is to be elected from such district, the Secretary of the Society shall mail a ballot containing the names of all nominees, arranged in alphabetical order, to each voting member in good standing of the Society in such Judicial District. Ballots shall be marked and returned to the office of the Society ~~not later than December 30th in the year 1965 and~~ not later than December 1st ~~in~~ each ~~succeeding~~ year and any ballot bearing postmark later than such date shall not be counted. Each ballot, to be valid, must be voted for neither a greater nor a smaller number of nominees than are to be elected from such district at such election. The ballot furnished to voting members shall have printed upon it a copy of the last preceding sentence.

The valid ballots so cast shall be tabulated and the results certified by ~~an independent service agency under the supervision of~~ the Secretary of the Society. In case of a tie vote, the winning candidate shall be determined by lot under the supervision of the Secretary. Those elected shall be notified by the Secretary and the names of those elected shall be made known to the members of the Society through publication in the Journal of the Society or by such other means as shall be directed by The Council.

COMMENT: These amendments remove the superfluous wording in the chapter regarding the 1965 elections and simplify the ballot-counting procedures since they are time-consuming and expensive and time has shown them to be unnecessary. The Judicial Commission concurs in this opinion.

4. *Component Society Constitutions and Bylaws on File at Headquarters*

RECOMMENDATION: Amend Chapter 1, Sec. 1, as follows: Sec. 1. CHARTER—The charter of each component county society shall be authorized by the House of Delegates and signed by the President and Secretary. Such charter shall require that the constitution and bylaws of such component county society be at all times consistent with the provisions of the Constitution and Bylaws of this Society and with all amendments thereto hereafter adopted. EACH COMPONENT COUNTY SOCIETY SHALL FILE WITH THE STATE SOCIETY HEADQUARTERS A CURRENT COPY OF ITS CONSTITUTION AND BYLAWS.

COMMENT: Component society constitutions and bylaws must be consistent with the MSMS Constitution and Bylaws, particularly the sections dealing with membership and ethics, mediation and grievance procedures. The Committee believes that these documents should be on file at MSMS headquarters so that they can be periodically reviewed.

5. *Deletion of Provisions for Quarterly Payment of Dues.*

RECOMMENDATION:

(1) Amend Chapter 4, Sec. 1. CHANGE OF LOCATION—PROCEDURE, first sentence, as follows: When a member of a component county society, by reason of a change of location, desires to transfer his membership to another component county society, he shall make application thereto accompanied by tender of dues for the remaining ~~quarters~~ HALF of the current year (any major fraction of a ~~quarter~~ HALF being regarded as a full ~~quarter~~ HALF and any minor fraction being disregarded.)

(2) Amend Chapter 4, Sec. 1 (c), as follows: (c) Component county society dues and assessments shall have been paid to cover that portion of the year in which application for transfer is made (any major fraction of a ~~quarter~~ HALF year being regarded as a full ~~quarter~~ HALF and any minor fraction being disregarded.)

(3) Amend Chapter 4, Sec. 2, as follows: Sec. 2. REFUND OF DUES—When a member shall have transferred to another component county society in accordance with the provisions of Sec. 1 above, he shall be entitled to a refund, from the Society from which he has transferred, of prepaid dues to such society (any major fraction of a ~~quarter~~ HALF year being regarded as a full ~~quarter~~ HALF and any minor fraction being disregarded.)

(4) Amend Chapter 4, Sec. 3, second paragraph, as follows: If the resigning member shall have prepaid dues to this Society or to his component county society for any period beyond the ~~quarter~~ HALF year in which his resignation becomes effective, such excess shall be refunded to him by the respective Societies.

(5) Amend Chapter 5, Sec. 3. NEW MEMBERS, first two sentences, as follows: For the purpose of determining the dues for new members only, the fiscal year of this Society shall be divided into ~~four three month~~ TWO SIX-MONTH periods. New members shall pay adjusted annual dues and assessments for the unexpired ~~quarterly~~ SEMI-ANNUAL periods of that year.

COMMENT: The MSMS Membership Director has indicated that the provisions for quarterly dues payments make the collection and processing of dues unnecessarily cumbersome. The Committee concurs and recommends that partial dues payments be permitted only on a semi-annual basis.

6. *Change in Dues Reduction for First Year of Practice.*

RECOMMENDATION: Amend Chapter 5, Sec. 4, as follows: Sec. 4. FIRST YEAR OF PRACTICE—The annual dues payable to this Society by a doctor of medicine who, by reason of his being elected to membership during his first year of practice, is granted a reduction of dues by his component ~~county~~ society, or if such component ~~county~~ society exacts no dues, shall be ~~one third~~ ONE HALF of the established amount during his first year of practice ~~and one half of the established amount during his second year of practice.~~ This reduction in annual dues shall not exempt such member from the payment of any regularly levied assessment.

COMMENT: While the Committee felt some reduction should be given to those first entering practice, it was felt that half-dues during the first year should be sufficient. The change would be in accordance with efforts to make the dues collection and processing more efficient and less cumbersome. The Committee notes that this provision only affects those who are entering practice for the first time anywhere, and not to physicians who move to Michigan after having been in practice elsewhere.

7. *Seating of Delegates and Alternates.*

RECOMMENDATION:

(1) Amend Chapter 9, Sec. 4, as follows: Sec. 4. SEATING-TENURE—A delegate, ~~or in his absence, an alternate delegate (in order of seniority.)~~ becomes a member of the House of Delegates when ~~duly registered and seated at the first scheduled regular session following certification~~ THE SPEAKER IS NOTIFIED OF HIS ELECTION, IN WRITING, by THE SECRETARY OF HIS ~~the~~ component society, specialty section or SAMA chapter~~, and remains a delegate until the expiration of his term~~. SUCH CERTIFICATION SHALL BE SUBMITTED BY FEBRUARY 1 OF EACH YEAR. THE DELEGATE SHALL REMAIN A MEMBER OF THE HOUSE OF DELEGATES UNTIL THE SPEAKER IS NOTIFIED IN WRITING BY THE SECRETARY OF THE COMPONENT SOCIETY, SPECIALTY SECTION OR SAMA CHAPTER THAT THE DELEGATE HAS BEEN REPLACED. THE DELEGATE SHALL REMAIN A MEMBER OF THE HOUSE OF DELEGATES FOR HIS FULL TERM REGARDLESS OF WHETHER OR NOT AN ALTERNATE SUBSTITUTES FOR HIM AT ANY MEETING OF THE HOUSE.

(2) Add new Chapter 9, Sec. 5, as follows, and appropriately renumber subsequent sections: Sec. 5. SEATING OF ALTERNATE DELEGATES—An alternate delegate (in order of seniority) may substitute for a duly certified delegate at any regular or special meeting of the House of Delegates provided that such substitution is authorized in writing by the secretary of the component society, specialty section or SAMA chapter.

COMMENT: The Committee believes that these procedures need to be simplified and clarified, and that no procedural hindrances should prevent a component society from selecting the persons it wishes to represent it in the House of Delegates.

8. *Councilors as Voting Members of the House of Delegates.*

RECOMMENDATION: Amend Chapter 9, Sec. 2, by adding the following sentence: Except for the Speaker, Vice-Speaker and Immediate Past President, members of The Council are not eligible for election as delegates by their component societies.

COMMENT: In considering the question, the Committee consulted with many past and present officers of MSMS. The general consensus was that for Councilors to serve as voting members of the House constituted a conflict of interest, since Councilors, in effect, would be sitting in judgment on actions of their own group. The Committee also agreed that the participation of MSMS members in their organization should be increased rather than diminished. If a Councilor also sits as a delegate, he then makes that seat unavailable to another member of MSMS who might otherwise participate.

9. *Medical School Deans as Members of the House of Delegates.*

RECOMMENDATION: Amend Chapter 9, Sec. 2, by adding the following paragraph: The dean of each accredited medical school in Michigan shall be a delegate-at-large to the House of Delegates, with voting privileges. An alternate may not be seated for him, and any provisions of these Bylaws regarding the seating of an alternate shall not apply.

COMMENT: In response to Resolution 72A-11, the Committee considered many ways of encouraging participation by the deans in medical society activities. It was agreed that their participation in the House of Delegates should be encouraged. It was noted that the deans might be other than doctors of medicine and not eligible for MSMS membership. This, of course, is also true of the student members of the House at present.

10. *Revision of MSMS Membership Classifications.*

RECOMMENDATION: That Chapter 2 of the MSMS Bylaws be revised to read as follows, and that Sections 8 and 9 of Chapter 5 be deleted: CHAPTER 2—MEMBERSHIP—CLASSIFICATION—ELECTION—

Sec. 1. DEFINITION—As used in these Bylaws, except as otherwise herein expressly qualified, whenever the terms "doctor of medicine" or "practice of medicine" or "medical profession" are used, these terms shall be deemed to include the terms "doctor of medicine and doctor of osteopathy," "practice of medicine and practice of osteopathy," and "medical profession and osteopathic profession."

Sec. 2. MEMBERSHIP PREREQUISITE—All members of the several component societies, when in good standing, are thereby and must be members of this Society.

Sec. 3. ACTIVE MEMBERS—To be eligible for active membership in any component society, a doctor of medicine must hold an unrevoked license in Michigan or, if unlicensed, must be engaged in academic teaching, research or administration. To maintain active membership in any component society, a doctor of medicine must maintain active membership in this Society and comply with all the provisions of the Bylaws of this Society and the component society.

Sec. 4. ACTIVE MEMBERS—DUES EXEMPT—A member in either of the following two categories shall be classified as "Active—Dues Exempt" and shall have all the privileges of active membership:

(a) Hardship—A member for whom the payment of dues would be a financial hardship by reason of physical disability or illness may be excused, fully or partially, from payment of dues by The Council provided the member is fully or partially exempted from the payment of component society dues. A member may also be excused from payment of dues because of financial hardship, or for other reason, but these must be set forth by the secretary of the member's component society.

(b) Postgraduate study—Active membership may be maintained without payment of dues for any member who is out of practice on account of postgraduate medical studies or in an approved residency training program providing such dues exemption is given by the component medical society.

Sec. 5. PHYSICIANS-IN-TRAINING—Component societies may admit to membership physicians still in training who have permanent license to practice medicine in Michigan. Such members shall have all privileges of active membership including the right to vote, but without the privilege of holding office. State Society dues shall be reduced, in an amount set by the House of Delegates, and component society dues shall be similarly reduced.

Sec. 6. STUDENTS—Component societies may admit to membership medical students and physicians in training who do not have a permanent license, as Student Members. Student members shall not pay dues to this Society nor the component society. They may receive MSMS publications authorized by The Council. They may not vote or hold office.

Sec. 7. RETIRED MEMBERS—A member who has maintained active membership in any one or more component societies in Michigan for a period of five or more years, and who has retired from practice, may be transferred to the retired members roster of such component society, provided his membership dues have been paid to the end of the preceding calendar year. A retired member shall pay no dues or assessments, but shall have the right to vote and hold office, and shall be entitled to receive publications at such rates as The Council may determine.

Upon request of the component society made at least thirty days in advance of an Annual Session of the House of Delegates and upon certification by the Secretary of this Society as to number of years of practice and membership in good standing, the House of Delegates may elect such member to retired membership in the Society.

Sec. 8. LIFE MEMBERS—

(a) A doctor of medicine who has maintained an active membership in good standing for twenty-five years in any one or more constituent state societies of the American Medical Association, with any five years in Michigan, with dues paid for the previous calendar year and who 1) has attained the age of 70 years or 2) has been in practice for 50 years, may, upon application and recommendation of his component society made at least 30 days in advance of an Annual Session of the House of Delegates, be elected by the House of Delegates to life membership in this Society. Such election shall be preceded by certification of the State Society in which he has maintained membership as to the required number of years of membership and good standing.

(b) Upon the adoption of this subdivision (b) all then living Past Presidents, Past Chairmen of The Council and Past Speakers of the House of Delegates of this Society shall automatically become life members of this Society and thereafter each President, Chairman of The Council and Speaker of the House of Delegates of this Society shall, upon retiring from office, become a life member of this Society without further action.

(c) A life member shall pay no dues or assessments but shall have the right to vote and hold office and shall be entitled to receive publications at such rates as The Council may determine.

Sec. 9—SERVICE MEMBERS—

(a) Military—A member in good standing who serves on active duty in the military forces of the United States may be transferred by the component society to Service Member status for the period of time he is in such service.

(b) Commissioned medical officers—A commissioned medical officer of the United States Army, Navy, Public Health Service, or physician employed by the Veterans Administration, on duty in this State, who is not engaged in the private practice of medicine, may be granted Service Member status by the component society in the area where he is located.

Service members shall pay no dues and are not entitled to vote or hold office. They shall be entitled to receive publications at such rates as The Council may determine.

Sec. 10. HONORARY MEMBERS—A component society may elect as an honorary member any person distinguished for his services or attainments in medicine or the allied sciences, or who has rendered other services of unusual value to organized medicine or the medical profession. Upon recommendation of a component society, the House of Delegates may elect such person an honorary member of the Society. An honorary member shall pay no dues and shall be without the right to vote or hold office in either this or the component society.

Sec. 11. NON-RESIDENT MEMBERS—A component society may elect as a non-resident member any doctor of medicine residing and practicing outside of the county who is a member in good standing of his own component society. A non-resident member shall not have the right to vote or hold office.

Sec. 12. AFFILIATE MEMBERS—Component societies may elect to affiliate membership lay persons in areas of endeavor which are related to medicine and medical practice. Affiliate members shall pay no dues and may not vote or hold office. They shall be entitled to receive publications at such rates as The Council may determine.

Sec. 13. RESOLUTIONS CONCERNING MEMBERSHIP CHANGES—Any change in membership status which requires action by the House of Delegates shall be effected by resolution presented in triplicate at an Annual Session of the House of Delegates after such secretarial certification as are required by these Bylaws.

COMMENT: The Committee believes that the membership classifications as now contained in the Bylaws are confusing, sometimes overlap, and should be modified to meet present needs.

The major changes recommended are:

(1) Establishment of a new category "Active Members—Dues Exempt" which will include present provisions re exemption for hardship and for postgraduate study, now contained in Chapter 5. This is simply a relocation of sections, not a change in language.

(2) Deletion of the Associate Member category. Persons now included in this category will be eligible for membership under other sections in the new Chapter.

(3) Addition of membership category for "Physicians-in-Training." This new category would allow physicians-in-training who are permanently licensed to become voting members of MSMS, but without the right to hold office. The dues would be reduced with the amount set by the House of Delegates. This provision is in line with AMA recommendations that state societies move toward granting house physicians full membership.

(4) Addition of membership category for "Students." This category would allow medical students or physicians-in-training who do not hold permanent licenses to become student members, without the right to vote or hold office, and with no dues. These provisions are similar to those previously applicable to associate members. This again is in line with AMA recommendations that state societies encourage full participation in organized medicine by medical students.

(5) Establishment of new category "Service Members" which would include previous categories of military members and commissioned medical officers.

(6) Addition of membership category for "Affiliate Members." This category includes some members presently included under Associate Members and allows component societies to admit to membership lay persons in areas of endeavor related to medicine and medical practice. Such members would not vote or hold office.

Other less important changes include clarification of language re the necessity of being a member of MSMS to be a member of the component society and vice versa, minor changes in the provisions for retired membership, and other "housekeeping" changes.

THE REFERENCE COMMITTEE ON CONSTITUTION AND BYLAWS, David J. Millard, MD, Acting Chairman, recommended approval on final reading of the Bylaws changes as presented in the Committee's printed report.

THE HOUSE approved these Bylaws changes on final reading as recommended by the Committee.

THE REFERENCE COMMITTEE recommended approval on first reading of the Bylaws amendments as presented in the Committee's printed report.

THE HOUSE further amended the proposed amendment in Item 9, Part II, by adding the words "who is an active member of MSMS" after the word "Michigan."

THE HOUSE then approved these Bylaws amendments, with the amendment noted above, on first reading, with the following exception:

THE HOUSE then referred the revision of MSMS Membership Classifications back to the Constitution and Bylaws Committee for further study.

(In accordance with Bylaws provisions, the amendments which were approved on first reading will be laid over to the next session for final consideration.)

14. Report of the Reference Committee on Ways and Means, James B. Blodgett, MD, Acting Chairman

The Ways and Means Committee was considerably aided in its deliberations by the advance work and data provided by its Chairman, Doctor David Siegel, who at the last minute was unable to attend this session.

Our duty is first, to review in detail the financial position of the MSMS based on the annual audited figures, and then to determine that the resources are adequate to carry out the Society's programs and objectives.

We studied in detail the annual audit and the Report of the Treasurer to this session.

The Committee finds that the financial reports are in order, and that our financial position is sound. It would commend Doctor Ylvisaker, the Treasurer, and Doctor Griffin, the Chairman of the Finance Committee of The Council, for their expert stewardship of the funds and accounts of the Society.

We assure the House that the special funds provided by the House for the Bureau of Economic Information are properly segregated and protected for the Bureau's sole use.

We note that the investment funds have shown a disappointing performance during the past fiscal year. This, however, is parallel to the experience of many other investment groups.

We recommend that next year the members of the Ways and Means Committee be provided with the *complete* audit report for their study in advance of the Spring Session.

THE HOUSE approved the report of the Reference Committee.

RESOLUTIONS

● RESOLUTION 73S-1

Of Commendation to Ingham County Physicians Who Care For Legislators

Thomas R. Berglund, MD, Kalamazoo County

House Action: Adopted

Whereas, members of Michigan's Legislature serve in Lansing, and are therefore separated by distance and time from their personal physicians, and

Whereas, frequently legislators require medical attention in Lansing, where they have no physician contacts, and

Whereas, several members of the Ingham County Medical Society have volunteered to attend to ailing legislators in addition to their own busy practices, which works a hardship on the physician but gains friends for MSMS in the legislative arena, and

Whereas, these physicians are too numerous to mention by name, but all provide their services in cooperation with the Ingham County Medical Society and MSMS, now therefore be it

RESOLVED: That MSMS commends the Ingham County Medical Society and its individual members who offer this politically sensitive service to legislators, thereby adding significantly to MSMS legislative acceptance; and be it further

RESOLVED: That a copy of this resolution be presented by an appropriate officer of the Michigan State Medical Society to the Ingham County Medical Society, as surrogate for the individual physicians providing the service, at a regular meeting of that component society.

● RESOLUTION 73S-2

Shortage of Family Physicians

Gordon W. Willoughby, MD, General Practice Section

House Action: Adopted as Amended

Whereas, there is an estimated shortage of family physicians in the nation, and

Whereas, there is an estimated shortage of family physicians in Michigan, and

Whereas, many of the students applying to medical schools indicate they want to be family physicians, therefore be it

RESOLVED: That the medical schools develop special family practice programs for students to provide more personal contact through preceptorships with practicing family physicians and in courses taught by family physicians, and be it further

RESOLVED: That the three schools be encouraged in their cooperative efforts in the development of this preceptorship project.

● RESOLUTION 73S-3

Section of General Practice Name Change

Gordon Willoughby, MD, General Practice Section

Constitution & Bylaws Committee
Stuart M. Gould, MD, Chairman

House Action: Adopted (The House passed on first reading the Bylaws change directed by this resolution. In accordance with Bylaws provisions, it will be laid over to the next session for final consideration.)

Whereas, being self evident, due to recent changes, be it hereby

RESOLVED: That the name of the Section of General Practice be changed to the Section of Family and General Practice.

● RESOLUTION 73S-4

Change of Medical Auxiliary

Robert J. Toteff, MD, Saginaw County

House Action: Adopted as Amended

Whereas, we are living in an age of affirmation of individual and constitutional rights, and

Whereas, it would be consistent to give equal rights to all mates of medical society members, regardless of sex, and

Whereas, under the present organization of the Woman's Auxiliary to the Michigan State Medical Society, there is discrimination to male mates of female members of Michigan State Medical Society, therefore be it

RESOLVED: That the Michigan State Medical Society encourage the "Woman's Auxiliary to the Michigan State Medical Society" to consider changing its name to the "Michigan State Medical Society Auxiliary" with equal rights and privileges for marriage partners of medical society members and be it further

RESOLVED: That our delegates to the AMA consider introducing a similar resolution for the AMA House of Delegates.

● RESOLUTION 73S-5

Payment for Medical Services by the State Department of Social Services

Harvey M. Andre, MD, Kent County

House Action: No Action

Whereas, the doctors of the State of Michigan are singled out to be paid at a discounted rate of an obsolete fee schedule, while providers of other services to the State are being paid at the going 1973 rate, therefore be it

RESOLVED: That MSMS take a firm stand against any governmental or other health care agency, attempting to fix fees at any previous year's prevailing fee schedules, or relative percentage thereof, and that firm action be taken to keep fees up-to-date, and be it further

RESOLVED: That the Legislature and the public be informed that the doctors of the State of Michigan are vigorously opposed to the present class discriminations by the reduction of fees for medical services, in contrast to fees allowed other providers of goods or services.

● RESOLUTION 73S-6

MSMS Deductible Health Insurance

E. G. Moehn, MD, Macomb County

House Action: Adopted as Amended

Whereas, the cost of Blue Cross-Blue Shield coverage is rapidly increasing, and

Whereas, physicians should show leadership by example in financial responsibility for medical care, and

Whereas, something for nothing inevitably leads to abuse of services, therefore be it

RESOLVED: That The Council of MSMS shall obtain and offer to the membership a deductible Health Insurance Policy.

● RESOLUTION 73S-7

On Determining Physicians' Fee Profiles

John B. Bryan, MD, Oakland County

House Action: Adopted as Amended

RESOLVED: That the Michigan State Medical Society request that Blue Shield and other insurance carriers providing health insurance policies to citizens of Michigan abanon setting physicians' profiles.

● RESOLUTION 73S-8

Chiropractic Practice in the State of Michigan

Richard H. Gascoigne, MD, Lenawee County

House Action: Adopted as Amended

Whereas, the MSMS recognizes that chiropractic theory and practice are not based upon the body of basic knowledge related to health, disease and health care that has been widely accepted by the scientific community and that the scope and quality of chiropractic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment; therefore be it

RESOLVED: That the MSMS vigorously pursue an active role in educating the consumer public and the medical profession regarding the fallacies, pitfalls and dangers of chiropractic, and be it further

RESOLVED: That MSMS oppose third party payments to chiropractors; and be it further

RESOLVED: That MSMS give strong, active support to the passage of anti-advertising legislation aimed at curbing the deceptive, fraudulent, harmful advertising by chiropractors, and be it further

RESOLVED: That the MSMS support any action that might be necessary to require as a prerequisite for future chiropractic licensure in the State of Michigan, a degree from a school that is accredited by an accrediting agency recognized by either the U.S. Office of Education or the National Commission on Accrediting, and be it further

RESOLVED: That MSMS seek ways and means to protect the public from the misuse of X-ray equipment by chiropractors; and be it further

RESOLVED: That MSMS inform its membership that it is considered unethical by the AMA and, henceforth, by the MSMS for a doctor of medicine to refer a patient to a chiropractor for *any* reason.

● RESOLUTION 73S-9

Presence of Physician at Blood Collecting Clinics

Edward R. Weddon, MD, Jackson County

House Action: Adopted

Whereas, the physical presence of a physician at a blood collecting site is neither necessary for the well being of the donors or efficacy of the program, and

Whereas, the present method is not an efficient utilization of a physician's available time, and

Whereas, alternate methods of medical supervision are workable and have previously been recommended by the MSMS House of Delegates in 1970, in Resolution 80, and

Whereas, The Council has previously recommended such an alternate method which would have a physician present within 15 minutes and available by telephone for consultation during the operation of the blood collecting clinic, therefore be it

RESOLVED: That Michigan State Medical Society urge that the rules be changed to permit the operation of a blood collecting unit with a physician on call, but not necessarily at the site.

● RESOLUTION 73S-10

Size of Malpractice Awards

Edward E. Elder, Jr., MD, Oakland County

House Action: Adopted as Amended

Whereas, the size of malpractice awards has reached astronomical heights, and

Whereas, the U.S. Malpractice Commission has apparently made no recommendation regarding the size of awards, and

Whereas, HR 5052, introduced in the first session of the 93rd Congress, establishes a Commission on Malpractice Awards, therefore be it

RESOLVED: That the appropriate legislative liaison committee of Michigan State Medical Society study HR-5052 and if it approves of the bill's purpose, support its passage in Congress.

● RESOLUTION 73S-11

Michigan Medicine Representation on Michigan Blue Shield Corporate Body

Thomas R. Berglund, MD, Kalamazoo County

House Action: The Following Substitute Resolution (in lieu of Res. 73S-11 and 73S-30) Disapproved

Whereas, sound policy in health care delivery and financing can best be established by communication between physicians and carrier, and

Whereas, MSMS has demonstrated its ability, through unified action, to negotiate with third-party representatives, and

Whereas, present physician representatives on the Blue Shield Corporate Board have indicated a desire for a source of information and policy; therefore be it

RESOLVED: That the MSMS House of Delegates select a special Blue Shield liaison committee to act in the interests of MSMS and in an advisory capacity to the physician representatives of the Blue Shield Corporate Board.

● RESOLUTION 73S-12

Group Medical Insurance Coverage for Michigan State Medical Society Members

W. J. Liedel, MD, Monroe County

House Action: No Action

Whereas, the Michigan State Medical Society has in the past secured low cost group insurance plans for its members, and

Whereas, the medical insurance coverage represents a substantial portion of Michigan physicians insurance costs, and

Whereas, the present medical insurance coverage under Blue Cross-Blue Shield Group 9400 costs almost $1,000 per family plan, and

Whereas, the Blue Cross-Blue Shield has to a major extent become a total prepayment plan rather than an insurance program, and

Whereas, the majority of physicians do not need or want a total pre-payment plan for medical costs, and

Whereas, the medical insurance with less extensive and unnecessary coverage could be purchased on a group plan through the Michigan State Medical Society, and

Whereas, the Michigan State Medical Society and the physicians of Michigan have no longer any proprietary interests in Blue Cross-Blue Shield and, therefore, should seek medical insurance coverage from the lowest bidder, therefore be it

RESOLVED: That Michigan State Medical Society develop immediately a high deductible and low deductible group medical insurance plan and submit said plan to all group insurance carriers for bids and make immediately available to the physicians of Michigan a lower cost group medical insurance program.

● RESOLUTION 73S-13

Change in Annual Sessions

Edwin J. Westfall, MD, Oakland County

House Action: Adopted as Amended and referred to Committee on Constitution & Bylaws

Whereas, the business of the Michigan State Medical Society usually can be completed in one session, and

Whereas, the Spring Session of the House of Delegates was scheduled to precede the Annual Meeting of the American Medical Association, therefore be it

RESOLVED: That the Michigan State Medical Society House of Delegates hold its Annual Session in the Spring allowing an option to the Speaker for calling an open meeting in the fall if deemed necessary.

● RESOLUTION 73S-14

Malpractice Screening

Jack M. Stack, MD, Gratiot County

House Action: Adopted as Amended

Whereas, nearly every physician in MSMS shares concern for the rising cost of medical malpractice insurance, and

Whereas, we are concerned about the detrimental effect on the public health care from the rising incidence of malpractice suits, and

Whereas, in certain states, the state medical society has set up a voluntary screening committee to which malpractice suits could be referred for evaluation and recommendation, and

Whereas, this mechanism has had the effect of decreasing malpractice suits and providing settlement in the interest of the public, therefore be it

RESOLVED: That MSMS investigate the advisability of establishing a committee of doctors, lawyers, and lay people to which malpractice suits could be taken for investigation and recommendation before going into court.

● RESOLUTION 73S-15

Blue Cross Hospital Payments

Maurice Chapin, MD, Tuscola County

House Action: Adopted

Whereas, MSMS policy has always supported the concept of the patient's right to seek their own care from the physician of their choice, and

Whereas, many Michigan citizens are subscribers to Blue Cross-Blue Shield, and

Whereas, Blue Shield pays physicians for covered services rendered, and

Whereas, Blue Cross does not presently pay for services in certain hospitals, and

Whereas, legislation has been introduced in the Michigan legislature to amend the Blue Cross regulatory law to state that a corporation such as Blue Cross shall not discriminate against its subscribers by denying a policyholder the right to select the hospital of his choice to furnish services provided under his policy, therefore be it

RESOLVED: That MSMS support such legislation thereby assuring patients covered by such a policy that the benefits of that policy are obtainable in any hospital licensed by the State Department of Public Health and accredited by the Joint Commission in Accreditation.

● RESOLUTION 73S-16

Relief from Governmental Economic Controls

Harvey M. Andre, MD, Kent County

House Action: Following Substitute Resolution (in lieu of 73S-16, 73S-19 and 73S-24) Adopted

Whereas, MSMS President John J. Coury, MD, seeks support for his stated position, namely, to remove physicians in practice from the discriminatory restriction upon medical fees in Phase III of the Federal Government's economic policies, therefore be it

RESOLVED: That the Michigan State Medical Society continue to seek relief from the discriminatory and restrictive policies in regard to physicians' fees in Phase III of the Board of Economic Stabilization."

● RESOLUTION 73S-17

Twenty-five Dollar Fee for Re-Registration to Practice

Edward E. Elder, Jr., MD, Oakland County

House Action: Disapproved

Whereas, the re-registration fee required annually to practice medicine in Michigan was recently raised to $25, and

Whereas, no doctor may continue to practice without registering, and

Whereas, many physicians have thus far refused to pay the higher fee, and

Whereas, other professions, such as lawyers and architects, are not required to pay a registration fee to the State, therefore be it

RESOLVED: That The MSMS Council urges the Legislature of Michigan to enact legislation to require similar registration fees from all professions and that the amount charged be only enough to defray the cost of operating the registration agency.

○ RESOLUTION 73S-18

Election of Interns, Residents and Fellows to Active Membership

Edward E. Elder, Jr., MD, Oakland County

House Action: No Action

Whereas, Chapter 2, Section 4 of the Bylaws of the Michigan State Medical Society limits residents, interns and fellows to Associate Membership in Michigan State Medical Society and the component county medical societies, and

Whereas, the trend nowadays is to involve the younger physicians in the main stream of medicine, and

Whereas, the active participation at the county and state level would encourage many of these physicians to stay and practice in Michigan, therefore be it

RESOLVED: That this House of Delegates amend the Bylaws to allow house staff MDs to become active, voting members of Michigan State Medical Society and their county medical society, with a reduced dues assessment.

● RESOLUTION 73S-19

Inequity and Discrimination of Phase III of the Government's Wage and Price Controls Upon Physicians

Lewis E. Simoni, MD, Genesee County

House Action: Substitute Resolution (in lieu of 73S-16, 73S-19, and 73S-24) Adopted. See 73S-16.

● RESOLUTION 73S-20

Compensation for Officers and Committee Members

Edward E. Elder, Jr., MD, Oakland County

House Action: Disapproved

Whereas, many officers of Michigan State Medical Society, committee chairmen and members of MSMS committees spend a large amount of valuable time on official business, and

Whereas, this limits the availability of our members for such activities, and

Whereas, PSRO and other on-coming activities will be even more time-consuming, therefore be it

RESOLVED: That the Michigan State Medical Society Council be empowered to make some compensation to the above personnel, when in The Council's judgment such expenditure is warranted, and the cost of doing so would not be prohibitive.

● RESOLUTION 73S-21

Medical Records as an Insurance Document

Henry A. Scovill, MD, Washtenaw County

House Action: Adopted

Whereas, it is the responsibility of the insurance carriers to prospectively define the medical services they cover to their subscribers and providers, therefore be it

RESOLVED: That Blue-Cross-Blue Shield be required to clearly define prospectively what documentation of these services is required by the provider in the medical records that Blue Cross-Blue Shield use for their audits at *all* hospitals, and be it further

RESOLVED: That since teaching institutions provide an important and complex type of medical service in combination with their training programs that Blue Cross-Blue Shield must define in advance the precise documentation which is required for each individual teaching institution based on the unique service provided.

● RESOLUTION 73S-22

Necessary Medical Examination versus Screening

Henry A. Scovill, MD, Washtenaw County

House Action: Adopted

Whereas, the necessity of pre-operative examinations including chest X-rays, EKG's and other laboratory determinations is clearly a matter of medical judgment, and

Whereas, Blue Shield has retrospectively defined many of these studies to be screening procedures not related to the patient's illness and has therefore requested reimbursement for payment already made, and

Whereas, the Judicial Council of the American Medical Association has stated that:

> "The practice of medicine by lay corporations is detrimental to the best interests of scientific medicine and of the people themselves. When medical service is made impersonal, when the humanities of medicine are removed, when the coldness and automaticity of the machine are substituted for the humane interest inherent in individual service and the professional and scientific independence of the individual physician, the greatest incentive to scientific improvement will be destroyed and the public will be poorly served." therefore be it

RESOLVED: That the Michigan State Medical Society reaffirm the obligation and right of the physician to determine those pre-operative tests that he or she deems necessary for patient care, and be it further

RESOLVED: That the Michigan State Medical Society declare that retrospective, arbitrary review of patients' records by a lay corporation such as Blue Shield, done primarily for the purpose of obtaining repayment from physicians for services deemed medically necessary and adequately performed, has a detrimental effect on the practice of medicine.

● RESOLUTION 73S-23

Seating of Delegates

Benjamin Jeffries, MD, Wayne County
for the Wayne County delegation

House Action: No Action

Whereas, there are some delegates who are unable to attend both sessions of the MSMS House of Delegates, and

Whereas, a delegate who has not been seated at the first session of the House of Delegates after his election cannot attend the subsequent meeting of the House, and

Whereas, delegates are the elected representatives of the component medical societies, and

Whereas, it should be the prerogative of the component medical society to certify its delegates to the Michigan State Medical Society, therefore be it

RESOLVED: That Chapter 9, Section 4, Seating-Tenure be amended to read as follows:

"Before each session a delegate, or in his absence an alternate delegate (in order of seniority), becomes a member of the House of Delegates when duly registered and seated, following certification by the component society, specialty section or SAMA chapter. In the absence of a delegate an alternate delegate may be seated for each session of the House of Delegates. A certified delegate remains a delegate until the expiration of his term."

● RESOLUTION 73S-24

Physicians' Fees in Phase III

Benjamin Jeffries, MD, Wayne County
for the Wayne County Delegation

House Action: Substitute Resolution (in lieu of 73S-16, 73S-19, and 73S-24) Adopted. See 73S-16.

● RESOLUTION 73S-25

Active Membership for Interns & Residents

Benjamin Jeffries, MD, Wayne County
for the Wayne County Delegation

House Action: No Action

Whereas, it is desirable to enlist physicians whenever possible to participate in, promulgate and support the policies of the Michigan State Medical Society; therefore be it

RESOLVED: That physicians licensed in Michigan and in postgraduate training, for example, interns, residents, and fellows, be made eligible for active membership and that they be given an appropriate dues structure in accordance with their earnings, and be it further

RESOLVED: That a section be established for the interns and residents.

● RESOLUTION 73S-26

Life Membership for Hardship Cases

Benjamin Jeffries, MD, Wayne County
for the Wayne County Delegation

House Action: Disapproved

Whereas, physicians who may by reason of protracted illness be unable to meet the dues assessment of MSMS, and

Whereas, such physicians may have to seek associate membership rather than continue active membership according to the Bylaws of the MSMS (Chapter 2, Sec. 4f); therefore be it

RESOLVED: That the Bylaws be amended to allow Active or Life membership by reason of hardship.

● RESOLUTION 73S-27

Notification for Formal Hearings

Benjamin Jeffries, MD, Wayne County
for the Wayne County Delegation

House Action: Adopted as Amended (The House passed on first reading these Bylaws changes. In accordance with Bylaws provisions, they will be laid over to the next session.)

Whereas, it has come to the attention of the Ethics Committee of the Wayne County Medical Society that the method of serving notice of formal hearings is too restrictive, and upon advice of our Legal Counsel, be it

RESOLVED: That the MSMS Bylaws, Chapter 6, Section 10 be amended to read. . . . "A written notice of such hearing, together with a copy of the formal complaint shall be served on the respondent by registered or certified mail or other appropriate means as approved by the MSMS Judicial Commission, not less than thirty days before the date of such hearing."

● RESOLUTION 73S-28

MSMS House of Delegates Meetings

Benjamin Jeffries, MD, Wayne County
for the Wayne County Delegation

House Action: Disapproved

Whereas, the Michigan State Medical Society is an organization unique to the State of Michigan, and

Whereas, the business of the Society is of particular relevance for the member physicians of this State, and

Whereas, transportation and travel should be convenient for all members of the Society, for consultants, advisors, the press, and the public; therefore be it

RESOLVED: That the House of Delegates meetings of the Michigan State Medical Society continue to be held in the State of Michigan and that the policy of the last Michigan State Medical Society meeting be rescinded in regard to holding meetings outside the State.

● RESOLUTION 73S-29

Malpractice Legislation

Benjamin Jeffries, MD, Wayne County
for the Wayne County Delegation

House Action: Adopted as Amended

Whereas, legislation reportedly will be introduced this spring by the Special Legislative Study Committee on malpractice actions and professional liability committee; and

Whereas, these proposed bills will:

(1) Amend the Statute of Fraud to provide that promises or warranties of cure or result of treatment of services shall be void unless in writing and signed by person charged or his designated agent;

(2) Reaffirm that the burden of proof shall be on the claimant and that evidence shall be dependent on medical expert testimony and not medical literature;

(3) Provide that a malpractice claim shall be accompanied by an "Affidavit of Merit," and

Whereas, this proposed legislation would have a remedial effect on malpractice claims, and

Whereas, adoption of these bills will require active support of every physician, therefore be it

RESOLVED: That The Council of the Michigan State Medical Society be instructed to keep each member informed as to the status of current malpractice legislation; and be it further

RESOLVED: That the Michigan State Medical Society should endorse this legislation and seek support from the insurance carriers, the Michigan State Bar Association, the Michigan Hospital Association and all other appropriate organizations.

● RESOLUTION 73S-30

Relations with Michigan Blue Shield

Benjamin Jeffries, MD, Wayne County
for the Wayne County Delegation

House Action: Substitute Resolution (in lieu of Res. 73S-11 and 73S-30) Disapproved. See Resolution 73S-11.

● RESOLUTION 73S-31

MSMS Liaison Committee with Michigan Department of Social Services

Benjamin Jeffries, MD
Wayne County Delegation

House Action: Adopted as Amended

Whereas, physicians who regularly treat, bill and collect for Medicaid services realize the extent and complexity of the problems inherent in the billing regulations and claims forms of the Michigan Department of Social Services, and

Whereas, these problems can best be resolved by the MSMS Liaison Committee with the Michigan Department of Social Services, and

Whereas, it is essential that Medicaid patients continue to have access to the services of private physicians, therefore be it

RESOLVED: That The MSMS Council appoint an ad hoc committee for Medicaid to continue liaison with the Department of Social Services and that the members of such a liaison committee be properly representative of physicians who regularly treat Medicaid patients and who have experience in billing for these services, and be it further

RESOLVED: That this committee report regularly to The Council and to the House of Delegates at each of its sessions.

● RESOLUTION 73S-32

PSRO

Walter B. Long, MD, Calhoun County

House Action: Disapproved

Whereas, the majority of the membership of the MSMS is opposed to the PSRO, and

Whereas, the PSRO will not further any savings in monies from the patient, taxpayer, or any insurance carriers, and

Whereas, most physicians are able to understand complex proposals of any kind, from any governmental agency, therefore be it

RESOLVED: That the MSMS serve notice on the State and Federal Governments that the membership shall in no way be involved with this scheme, that in no way, benefits the patients or the people of Michigan.

● RESOLUTION 73S-33

Quality Assurance Program

Walter B. Long, MD, Calhoun County

House Action: Disapproved

Whereas, The Computerized Average Length of Stay Programs constitute an unwarranted intervention in the practice of medicine and must be condemned as exerting third party pressure on the freedom of physician judgment, and are certain to injure the treatment of patients, and

Whereas, QAP is a composite of CHAPS, ALS, AID, PSRO, HASP, PAS programs and other forms of computerized standardization of medicine which are against established medical policy quoted above, as well as MSMS policy, and

Whereas, the proposed QAP can therefore only lead to the deterioration, not the assurance of quality medical care, as well as stifle innovation and medical progress by establishing federal rules for diagnosis and treatment of patients, and

Whereas, QAP would exert economic pressures to substitute computerized averages for individual physician judgment, and

Whereas, QAP reflects on the integrity of the physician, interferes with his judgment and sets up an expensive bureaucracy which increases medical care costs and limits the proper treatment of his patient, therefore be it

RESOLVED: That MSMS rejects the proposed Quality Assurance Program, and that copy of the Resolution be sent to the Governor of Michigan, President of the United States and Secretary of HEW.

● RESOLUTION 73S-34

Insurance Forms

Walter B. Long, MD, Calhoun County

House Action: Adopted as Amended

Whereas, many insurance carriers and governmental agencies have many different and confusing forms, and

Whereas, the different agencies and companies have different nomenclature and codes, therefore be it

RESOLVED: That the MSMS will work towards a standard invoice form and one standard nomenclature.

● RESOLUTION 73S-35

National Tumor Registry

Walter B. Long, MD, Calhoun County

House Action: Disapproved

Whereas, the National Tumor Registry dissolves the concept of invasion of privacy as pertains to patient records, and

Whereas, the MSMS rejects the concept of a National Board determining who will and who will not treat patients, and

Whereas, the treatment of patients is a private and confidential agreement between a patient and his or her physician, therefore be it

RESOLVED: That the MSMS rejects the concept of a National Tumor Registry or any National Medical Registry of any form and nature, and refuses to involve itself in this program.

● RESOLUTION 73S-36

Blue Shield Agreements

Walter B. Long, MD, Calhoun County

House Action: Referred, without action, to The Council for further study and recommendation

Whereas, no other insurance company requires physicians to sign a contractual relationship, and

Whereas, Blue Shield requires a written agreement for physicians to receive less than their just recompense, and

Whereas, such a written agreement is discriminatory and flagrant violation of an individual physician's civil rights, and

Whereas, the Federal Government has made price fixing an illegal act, and

Whereas, Blue Shield failed to inform most doctors of the difference of fee payments as to area, therefore be it

RESOLVED: That MSMS require and demand Blue Shield to immediately rescind all and any requirements for any signed agreements of any kind, in order that a particular physician receive his monies due.

● RESOLUTION 73S-37

Fiscal Notes on Reports and Resolutions

D. Bonta Hiscoe, MD, Ingham County

House Action: Adopted as Amended

Whereas, the American Medical Association at its recent meeting adopted a policy requiring fiscal notes on all resolutions and reports prior to their consideration by the House of Delegates, and

Whereas, this policy would seem to be appropriate also for the Michigan State Medical Society, therefore be it

RESOLVED: Where appropriate, reports to the House of Delegates from The Council or Committees and resolutions introduced in the House of Delegates shall include a fiscal note made by The Council or the Committee or the sponsor of the resolution, and be it further

RESOLVED: That such fiscal notes shall set forth the estimated costs, if any, of such policy program or action proposed by such report or resolution, and be it further

RESOLVED: That no report or resolution may be considered by this House without the attachment of such fiscal note.

• RESOLUTION 73S-38

Ethical Considerations Regarding Physician Involvement in Laboratories, X-ray Facilities and Pharmacies

John C. Benson, MD, Genesee County

House Action: Withdrawn

• RESOLUTION 73S-39

The Medicaid Performance, Surveillance & Utilization Report System

Marion G. McCall, MD, Wayne County

House Action: Adopted as Amended

Whereas, Michigan State Medical Society is participating in the Medicaid Performance, Surveillance & Utilization Report System, and

Whereas, in 1971 the component medical societies were advised that the physician consultants appointed by the Michigan State Medical Society to this program would report on a regular basis, and

Whereas, The Michigan Department of Social Services now rejects Medicaid claims on the basis of its "exception reporting" screen, and

Whereas, no reports have been received by this House of Delegates as to how these exceptions to the screen of the Medicaid Program were determined nor has any statistical date been received about the utilization and frequency of use pattern of this program, therefore be it

RESOLVED: That the consultants to the Medicaid Performance, Surveillance and Utilization Report System be requested to submit current reports of their activities and progress to The Council and if indicated, copies are to be submitted to each component medical society.

• RESOLUTION 73S-40

Ethical Principles of Professional Standard Review Organizations

Sidney E. Chapin, MD, Wayne County

House Action: No Action

Whereas, The Professional Standard Review Organizations, as mandated by PL 92-103, will have a significant effect on the practice of medicine, and

Whereas, the MSMS Ad Hoc Committee to Coordinate PSRO Activity in Michigan is directing its efforts to the organizational aspects of PSROs, and

Whereas, serious consideration should be given to the medical principles involved in PSROs and the ethical and legal questions, such as, quality of care, confidentiality of records, physicians' malpractice liability, the role of the consumer, therefore be it

RESOLVED: That The Council appoint an Ad Hoc Committee to study these issues and to develop guidelines for physicians in their relations to Professional Standard Review Organizations, and be it further

RESOLVED: That this Ad Hoc Committee be granted an adequate budget to carry out this important assignment.

• RESOLUTION 73S-41

Abortions

Lee B. Stevenson, MD, Wayne County, for the Committee on Maternal and Perinatal Health

House Action: Adopted as Amended

Whereas, the United States Supreme Court decisions on abortion have caused the Michigan Attorney General to declare Michigan's abortion laws unconstitutional, and that statutes governing voluntary termination of pregnancy in the first trimester cannot be effectively enacted; and

Whereas, the resultant lack of control mechanisms of any kind has caused confusion and the threat of exploitation, and

Whereas, the Michigan Department of Public Health subsequently has promulgated "guidelines" establishing quality control criteria and defining standards of medical practice in the performance of abortions; and

Whereas, the guidelines can only be advisory and lack enforcement capability; therefore be it

RESOLVED: That the Michigan State Medical Society endorses the guidelines of the Michigan Department of Public Health as proper quality control criteria for voluntary termination of pregnancies, and advises those members who choose to provide abortion services to adhere to the guidelines as the established medical practice standard in Michigan with respect to abortions, and be it further

RESOLVED: That only pregnancies of less than fourteen (14) weeks after the onset of the last menstrual period may be terminated outside of a licensed hospital, and be it further

RESOLVED: That the Michigan Department of Public Health be empowered to inspect and approve or disapprove facilities for termination of all pregnancies in Michigan, and be it further

RESOLVED: That the Michigan State Medical Society use every resource to assure that the Michigan Department of Social Service and medical insurance companies make provision for adequate coverage for this service.

• RESOLUTION 73S-42

Continuation of Federal Financial Support to Schools of Public Health

Neal A. Vanselow, MD, Washtenaw County

House Action: No Action

Whereas, the President of the United States and the Congress have for fifteen years been urging the schools of public health to expand in order to help supply desperately needed health personnel, and

Whereas, documentation presented to the Congress by the Association of Schools of Public Health supports the role of schools of public health in fulfilling the task of preparing health manpower for the nation, and

Whereas, preparation of needed health personnel and the continued effectiveness of schools of public health for this purpose are being placed in extreme jeopardy by the President's recent decision to discontinue all federal aid to them, and

Whereas, the Board of Trustees of the American Medical Association has publicly supported this decision by the President without citing reasons for its action, therefore be it

RESOLVED: That the Michigan Sttae Medical Society request the American Medical Association Board of Trustees to reverse its stand on this issue, and be it further

RESOLVED: That the Michigan State Medical Society request the American Medical Association to vigorously support continuation of federal aid to schools of public health

REFERENCE COMMITTEES

1973 SPRING SESSION

COMMITTEE "A"

Norman Bolton, MD, Wayne, *Chairman*
Charles E. Darling, MD, Wayne
John W. Grigg, MD, Otolaryngology Sec.
Warren J. Liedel, MD, Monroe
Keate T. McGunegle, MD, Sanilac

James R. Quinn, MD, Oakland
S. A. Yannitelli, MD, Calhoun
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Ralph R. Cooper, MD
Wm. A. DeYoung, MD
Robert M. Stow, MD
Edward J. Tallant, MD

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Dwight J. Dutcher, MD, Wayne
Thomas M. Flake, MD, Wayne
William Haeck, MD, Kent
F. Alan Kennedy, MD, Berrien
John M. Wood, MD, Isabella-Clare
Councilor Advisors:
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Adam C. McClay, MD
James H. Tisdel, MD
Louis R. Zako, MD

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F. C. O'Dell, Jr., MD, Alpena
Joseph L. Ponka, MD, Wayne
Thomas J. Setter, MD, Macomb
Lewis E. Simoni, MD, Genesee
Arthur A. Ulmer, MD, Wayne
Gordon W. Willoughby, MD, Gen. Practice Sec.
Councilor Advisors:
Noyes L. Avery, Jr., MD
Raymond L. Hockstad, MD
Louis E. Heideman, MD
Paul T. Lahti, MD
W. Kaye Locklin, MD

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Thomas R. Berglund, MD, Kalamazoo
John Bruder, Wayne State SAMA
Henry T. Forsyth, MD, Saginaw
Gerald H. Mandell, MD, Wayne
George Mogill, MD, Wayne
Paul L. Trump, MD, Dickinson-Iron
Councilor Advisors:
Leland E. Holly II, MD
Robert C. Prophater, MD
Donato F. Sarapo, MD
Donald N. Sweeny, Jr., MD

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Stuart M. Gould, MD, Washtenaw, *Chairman*
Paul R. Dumke, MD, Wayne
Arthur F. Dundon, MD, Grand Traverse-Leelanau
David J. Millard, MD, Van Buren
Lee B. Stevenson, MD, Wayne
Leo W. Walker, MD, Pathology Section
Donald I. Bryan, MD, Wayne, Advisor
Councilor Advisors:
Kenneth H. Johnson, MD
Sydney Scher, MD

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John C. Benson, MD, Genesee
Vincent J. Gallant, MD, Wayne
James M. Kennary, Sr., MD, Wayne
Frank L. Pettinga, MD, Muskegon
Kenneth L. Urwiller, MD, Oakland
Charles H. Willison, MD, Midland

RULES & ORDER OF BUSINESS

James C. Danforth, Jr., MD, Wayne, *Chairman*
Harvey N. Andre, MD, Kent
Ned I. Chalat, MD, Wayne
Roy J. Gerard, MD, Saginaw
D. Bonta Hiscoe, MD, Ingham
John H. McLaughlin, MD, Oakland
Henry A. Scovill, MD, Washtenaw

WAYS & MEANS

David Siegel, MD, Urology Section, *Chairman*
Robert W. Black, MD, Wayne
James Blodgett, MD, Wayne
Marion G. McCall, MD, Wayne
John W. Moses, MD, Wayne
Charles L. Oppy, MD, North Central
Jack R. Postle, MD, Northern Michigan
Councilor Advisors:
Ernest P. Griffin, Jr., MD
John R. Ylvisaker, MD

RECORD OF ATTENDANCE

1973 MSMS House of Delegates
Spring Meeting

	Meetings	
	1st	2nd
OFFICERS:		
Speaker:		
Vernon V. Bass, MD	x	x
Vice Speaker:		
James D. Fryfogle, MD	x	x
Immed. Past President:		
Sidney Adler, MD	—	—
Secretary:		
Kenneth H. Johnson, MD	x	x
DELEGATES		
ALLEGAN		
R. L. Plagenhoef, MD	x	x
ALPENA-ALCONA-PRESQUE ISLE		
F. C. O'Dell, Jr., MD	x	x
BARRY		
Larry L. Blair, MD	x	x
BAY-ARENAC-IOSCO		
John W. Grigg, MD	—	—
John T. Geneczko, MD	x	x
BERRIEN		
Fredk. H. Lindenfeld, MD	x	x
F. Alan Kennedy, MD	x	x
BRANCH		
Henry C. Gomley, MD	x	x
CALHOUN		
George T. Kelleher, MD	—	—
S. A. Yannitelli, MD	x	x
Walter B. Long, MD	—	—
CASS		
Not Represented		
CHIPPEWA-MACKINAC		
Not Represented		
CLINTON		
James M. Grost, MD	x	—
DELTA-SCHOOLCRAFT		
Donald N. Fitch, MD	x	x
DICKINSON-IRON		
Paul L. Trump, MD	—	x
EATON		
Eber B. Sherman, MD	x	x
GENESEE		
John W. MacKenzie, MD		
Glenn E. Moore, MD	x	x
Charles A. Thompson, MD	x	x
John C. Benson, MD	x	x
Lewis E. Simoni, MD	x	x
Richard J. McMurray, MD	x	x
John Quin, Jr., MD		
R. L. Rapport, MD	x	x
Joseph T. Batdorf, MD	x	
Carl H. Mangelsdorf, MD		x
GOGEBIC		
Not Represented		
GRAND TRAVERSE-LEELANAU-BENZIE		
Arthur F. Dundon, MD	x	x
Kenneth H. Musson, MD	x	x
GRATIOT		
Jack M. Stack, MD	x	—
HILLSDALE		
Not Represented		
HOUGHTON-BARAGA-KEWEENAW		
Paul G. Goodreau, MD	x	x
HURON		
Charles W. Oakes, Jr., MD	x	x
INGHAM		
George D. Stilwill, MD		
Donald J. Aiken, MD	x	x

	Meetings 1st	Meetings 2nd
Thomas C. Blair, MD	x	x
Justin L. Sleight, MD	—	x
D. Bonta Hiscoe, MD	x	x
Henry E. Malcolm, MD	x	x
Harry C. George, MD	x	x
Thomas C. Payne, MD	x	—
IONIA-MONTCALM		
Robert E. Rice, MD	x	x
ISABELLA-CLARE		
John M. Wood, MD	x	x
JACKSON		
Edward R. Weddon, MD	x	x
Richard C. Deming, MD	x	x
KALAMAZOO		
Thomas R. Berglund, MD	x	x
Robert C. Kettunen, MD	x	—
Harold R. Reames, MD	x	x
Douglas A. Haddock, MD	x	x
KENT		
Harvey M. Andre, MD	x	x
Victor A. Notier, MD	x	x
William E. Kincaid, MD	x	x
Jack G. Lukens, MD		
Robert D. Burton, MD	x	x
Kornelius Van Goor, MD	x	x
Fred C. Brace, MD	x	x
Frederick S. Gillett, MD	x	x
William Haeck, MD	x	x
Richard A. Rasmussen, MD	x	—
LAPEER		
Charles E. Conaway, MD	x	x
LENAWEE		
Richard H. Gascoigne, MD	x	x
LIVINGSTON		
Edwin S. Woodworth, MD	x	x
LUCE		
Not Represented		
MACOMB		
Earl G. Moehn, MD	x	x
Thomas J. Setter, MD	x	x
Joseph J. LaHood, MD		
Orville W. Oughtred, MD	x	x
Ronald J. Sables, MD	—	—
Jule J. Merritt, MD	x	x
MANISTEE		
Vickers C. Hansen, MD	x	x
MARQUETTE-ALGER		
George M. Wilson, Jr., MD	x	x
MASON		
William F. Sutter, MD	x	x
MECOSTA-OSCEOLA-LAKE		
Jerome A. Conrad, MD	x	x
MENOMINEE		
William S. Jones, Jr., MD	x	x
MIDLAND		
Charles H. Willison, MD	x	x
MONROE		
Warren J. Liedel, MD	x	x
MUSKEGON		
Leland E. Holly II, MD	x	x
Richard T. Allen, MD	x	x
Frank L. Pettinga, MD	x	x
NEWAYGO		
Robert E. Paxton, MD	x	x
NORTH CENTRAL		
Charles L. Oppy, MD	x	x
NORTHERN MICHIGAN		
Jack R. Postle, MD	x	x
Russell F. LaBeau, MD	x	x
OAKLAND		
Kenneth L. Urwiller, MD	x	x
John B. Bryan, MD	x	x
Keith M. Holmes, MD	—	x
Edwin J. Westfall, MD		
Richard E. Straith, MD	x	x
Worth W. Henderson, MD	x	x
John H. McLaughlin, MD	x	x
James R. Quinn, MD	x	x
Peter A. Duhamel, MD	x	x
Edward E. Elder, Jr., MD	—	x
Arnold L. Brown, MD	x	x
E. William Bauer, MD	x	x
James A. Read, MD	x	x
Francis A. Martin, MD	x	x
Fred W. Bryant, MD	—	—
Wayne T. Good, MD		
Jalme V. Aragones, MD	x	x
OCEANA		
John J. Vrbanac, MD	x	x

	Meetings 1st	Meetings 2nd
ONTONAGON		
Not Represented		
OTTAWA		
Peter J. Verkaik, MD	x	x
Alvin Bonzelaar, MD	x	x
SAGINAW		
Jack L. Barry, MD	x	x
Vernon V. Bass, MD		
Robert Jardinico, MD	x	x
Roy J. Gerard, MD	x	x
Robert J. Toteff, MD	x	x
ST. CLAIR		
Daniel J. Wilhelm, MD	—	—
Charles N. Hoyt, MD	x	x
ST. JOSEPH		
Robert H. Evans, MD	x	x
SANILAC		
Keate T. McGunegle, MD	x	—
SHIAWASSEE		
Henry T. Forsyth, MD	x	x
TUSCOLA		
Maurice H. Chapin, MD	x	x
VAN BUREN		
David J. Millard, MD	x	x
WASHTENAW		
Henry A. Scovill, MD	x	x
Lyle D. Elliott, MD	x	x
Harold F. Falls, MD	x	x
George H. Koepke, MD	x	x
Robert J. Fisher, MD		
R. N. Powsner, MD	x	x
Neal A. Vanselow, MD	x	x
Stuart M. Gould, Jr., MD		
Robert M. Oneal, MD	x	—
John W. Henderson, MD	x	x
Beverly C. Payne, MD		
Frank L. Purcell, MD	x	x
WAYNE		
Sidney E. Chapin, MD	x	x
Ned I. Chalat, MD	x	—
James D. Fryfogle, MD	x	x
Homer M. Smathers, MD	x	x
Brock E. Brush, MD	x	x
Charles E. Darling, MD	x	x
James C. Danforth, Jr., MD	x	x
Marjorie P. Meyers, MD	x	x
James B. Blodgett, MD	x	x
Louis E. Heideman, MD	x	—
Alexander Blain III, MD	x	x
Paul J. Connolly, MD	x	x
James M. Kennary, Sr., MD	x	x
John W. Moses, MD	x	—
Robert D. Allaben, MD	x	—
Kenneth L. Krabbenhoft, MD	x	x
Benjamin Jeffries, MD	x	x
Frank B. Walker, MD	x	x
Francis P. Rhoades, MD	x	x
Thomas M. Flake, MD	x	x
George F. Porretta, MD	x	x
Eli J. Igna, MD	x	x
Kenneth J. Ray, MD	—	x
George Mogill, MD	x	x
Richard D. Anslow, MD	x	—
Norman Bolton, MD	x	x
Dwight J. Dutcher, MD	x	x
Louis R. Zako, MD	x	x
Vincent J. Gallant, MD	x	x
Gerald H. Mandell, MD	x	x
Boy Frame, MD	x	—
Lee B. Stevenson, MD	x	x
Charles C. Vincent, MD	x	—
Robert W. Black, MD	x	x
Andrew J. Hopkins, MD	x	x
Robert P. Lilly, MD	x	x
Louis F. Hayes, MD	x	x
Charles Kessler, MD	x	—
Marion G. McCall, MD	x	x
WEXFORD-MISSAUKEE		
Dennis E. Van Alst, MD	x	x
MEDICAL SCHOOLS:		
MICHIGAN STATE UNIVERSITY		
Not Represented		
WAYNE STATE UNIVERSITY		
John Bruder	—	x
UNIVERSITY OF MICHIGAN		
Not Represented		
SECTIONS:		
ALLERGY & APPLIED IMMUNOLOGY		
James A. McLean, MD	—	x
ANESTHESIOLOGY		
Not Represented		

	Meetings	
	1st	2nd
DERMATOLOGY Robert J. Schoenfeld, MD	x	x
GASTROENTEROLOGY David S. Greenbaum, MD	x	x
GENERAL PRACTICE Gordon W. Willoughby, MD	x	x
INTERNAL MEDICINE Bernard J. Sweeney, MD	x	x
NEUROLOGY Not Represented		
NEUROLOGICAL SURGEONS Not Represented		
OBSTETRICS-GYNECOLOGY Joseph A. Caruso, MD	x	x
OCCUPATIONAL MEDICINE William L. Berridge, MD	x	x
OPHTHALMOLOGY Not Represented		
ORTHOPEDIC SURGERY Hira E. Branch, MD	x	x
OTOLARYNGOLOGY Not Represented		

	Meetings	
	1st	2nd
PATHOLOGY Not Represented		
PEDIATRICS Not Represented		
PHYSICAL MEDICINE Not Represented		
PLASTIC SURGERY Richard E. Straith, MD	x	x
PROCTOLOGY Not Represented		
PSYCHIATRY Stephen C. Mason III, MD	x	x
PUBLIC HEALTH AND PREVENTIVE MEDICINE Not Represented		
RADIOLOGY Kenneth D. McGinnis, MD	x	x
SURGERY Michael N. Zelenock, MD	x	—
THORACIC SURGERY Not Represented		
UROLOGY Not Represented		

MSMS PLANS CME CERTIFICATION

New MSMS Commission Seeks to Develop Continuing Education Certification Plan

By Herbert A. Auer, Manager
MSMS Department of Communications

A continuing education certification plan for Michigan physicians is being explored by a new MSMS Commission on Continuing Medical Education.

The 1972 fall House of Delegates created the Commission and charted its course when it approved recommendations presented by an ad hoc committee.

Louis E. Heideman, MD, Detroit pediatrician, medical educator and member of the MSMS Council, is chairman of the MSMS Commission. Serving with him are Robert Blackhurst, MD, Midland; David S. Greenbaum, MD, MSU College of Human Medicine; Cecelia F. Hissong, MD, Dearborn; Conrad Lam, MD, Detroit, and Richard W. Pomeroy, MD, Lansing.

The 1972 House gave these directions to the Commission:

> *"To develop a flexible series of minimal continuing education standards for physicians practicing in Michigan. That such standards be based on a broad approach requiring a set number of credits using facilities and approved programs of hospitals, medical schools, county, state and national medical societies, and other current and developing methods of continuing medical education as determined by the permanent commission. That MSMS establish basic principles of approval for all continuing medical education programs in Michigan and also guidelines for reciprocity with accredited programs of other state, regional and national organizations."*

The 1973 Spring meeting of the House of Delegates also called for the development of a Michigan CME certification program as one of the 21 current and intermediate objectives approved for MSMS, as recommended by the MSMS Committee on Planning and Priorities.

States adopt different approaches to encourage continuing learning

MSMS, other state medical societies, and the medical specialty organizations are all either studying CME opportunities or have started new projects.

The AMA reports that 7 medical societies (Oregon, Arizona, Pennsylvania, North Carolina, New Jersey, Massachusetts, and Florida) have made policy decisions that will require CME as a condition for membership.

Pres. Coury Makes 3 Appeals

By John J. Coury, MD,
MSMS President

Let me make this quick appeal to every MSMS member to plan to participate Oct. 10 and 11 in the MSMS Annual Scientific Session in Detroit. The journal cover this month properly focuses on that important postgraduate education experience.

And may I also call your attention to my message this month about continuing medical education. I would welcome your comments and your views. Just write to me at MSMS.

Please read this CME feature and look forward to reports that will be coming from the New MSMS Commission on Continuing Medical Education. Thank you.

Oregon, Arizona, Pennsylvania and California have endorsed the AMA Physician's Recognition Award as the basis for their own state CME certification programs.

In three states, the State Board of Medical Examiners has been granted the necessary authority to require evidence of continuing medical education as a condition for registration of the license to practice. They are Kansas, New Mexico, and Maryland. New Mexico is the only one to date to put its authority into effect.

The AMA has approved the following state medical societies for accreditation or organizations or institutions sponsoring integrated continuing medical education programs. They are California, Pennsylvania, Tennessee, Maryland, Connecticut, Illinois, Indiana, Georgia, District of Columbia, New Mexico, West Virginia, New Jersey, and Arizona.

One of the best known state society voluntary CME programs is California. The California Medical Association began its planning in 1967 when the decision was made to make the community hospital the focal point for CME work, and for measurement of learning and application. CMA began its CME accreditation project in 1970.

Oregon was first state medical society to establish CME as a prerequisite for membership. On Jan. 1, 1971, when the program went into effect, 11 doctors were suspended but five later met requirements and were taken back in.

Oregon feels doctors have a responsibility to continue their education and every doctor is held to meet the requirement. The reporting form is simple. Some doctors report by WATTS telephone line to the Oregon State Society to fill in their forms.

AMA establishes criteria to accredit CME courses, seminars

The AMA Council on Medical Education moved several years ago into the CME gap with a program of voluntary accreditation of institutions and organizations offering continuing medical education courses. Under this program, medical schools, hospitals, medical societies, volunteer health agencies, and other groups offering courses have, themselves requested surveys to assure that their efforts are up to at least minimum standards, as measured by an outside evaluator.

Criteria used for accreditation, developed by the AMA Advisory Committee on Continuing Medical Education, include:

1. Administration by a person responsible for supervising and coordinating efforts in all courses presented by his institution, and charged with assuring that all courses are well planned and well presented.

2. A budget adequate to the program undertaken, with financial support from the institution, as well as from tuition fees.

3. A teaching staff of proven ability and experience, dedicated to the goals of education generally, and their program in particular.

4. A well-planned curriculum designed to probe one topic or group of closely related topics in depth, rather than merely skim the surface of a broad subject area.

5. Availability of appropriate facilities and teaching aids, such as conference rooms, libraries, laboratories, and audio-visual aids.

6. Use of education methods such as question and discussion periods, laboratory work, and clinical experience, which encourage active input and involvement by the physician-students.

7. Methods of evaluating the benefits of the course as a teaching tool, starting with specific objectives for measurement.

8. A philosophy of physician rewards that emphasizes the benefits of the physician's improved ability to care for his patients and the stimulation of his own spirit of intellectual adventure.

The AMA reviews state society accreditation programs. Where state programs meet proper standards, the institutions they accredit will be eligible to list their courses in future AMA directories.

AMA endorses 2,441 CME courses in nation this coming year.

A total of 2,441 courses for continuing education of American physicians will be offered by 697 institutions and organizations in the year beginning Sept. 1.

This figure compares to 2,082 courses listed a year ago by the AMA's Department of Continuing Medical Education.

REGISTRATION

The MSMS purpose "to seek to advance the medical knowledge of its members" has always been the major goal of the MSMS Annual Session each fall. These doctors are registering and waiting for the next program to begin at the 1972 meeting. The 1973 scientific program will be Wednesday, Oct. 10 and Thursday, Oct. 11 at the Sheraton-Cadillac Hotel in Detroit.

Applications for AMA Award Available from AMA

MSMS members who are interested may obtain from the AMA an informational booklet about the AMA Physician's Recognition Award, and an application form.

Inquiries should be addressed to Department of Continuing Medical Education, American Medical Association, 535 N. Dearborn Street, Chicago, Ill 60610.

AMERICAN MEDICAL ASSOCIATION
Continuing
Medical Education
AWARD

C. H. William Ruhe, MD, the AMA's Director of Medical Education, reports "the number of physicians recognizing the value of regular, formal study has been increasing steadily and participation in the listed courses continues to grow."

A major factor in continuing medical education of physicians is the AMA's Physician's Recognition Award, presented to physicians who successfully complete specified study programs.

More and more physicians apply for AMA physician's recognition award

"More physicians from Michigan and the nation are applying every year for the 'AMA Physician's Recognition Award,' " reports Doctor Ruhe.

Since the award was established by the AMA in 1969 a total of more than 40,000 physicians have qualified for it.

The resolution which created the award called for 150 credit hours of continuing medical education over a 3-year period. In 1972 the criteria were revised and broadened. Now 60 of the 150 hours must be in the form of courses given by institutions accredited by the AMA or a state society accrediting program.

The new criteria give credit for many more kinds of continuing medical education, including new and innovative kinds of activities, such as self-assessment and individual reading, and they enhance and support continuing education programs sponsored by state medical and medical specialty societies.

"From an AMA organizational standpoint, the new criteria have potential for generating data that can maintain and improve the leadership of the profession in the field of continuing medical education, and also can support negotiations for lower group malpractice insurance rates," Doctor Ruhe adds.

The AMA award is a professional service for all physicians sponsored on a voluntary basis with the ultimate goal to improve patient care under the leadership of the profession.

Representative to AMA Conference Sees Great CME Potential for MSMS

After the 1972 AMA Conference on Continuing Medical Education, The MSMS Council received a report from its designated participant David S. Greenbaum, MD, who wrote in part:

"There was a persistent and pervasive message of the immense pressures building up at federal levels for accountability of the entire health care profession."

Doctor Greenbaum continued, "It was frequently noted that there soon will be many requirements imposed upon the profession and that the decisions relating to these requirements may be made without participation by practicing physicians and may thus be unrealistic and unduly burdensome. For this rather negative reason as much for the potentially desirable aspects of patient care appraisal, it was emphasized that the profession should satisfactorily demonstrate that it can provide an evaluation and correction mechanism for delivery of health care better than the government.

"It is my feeling that Michigan State Medical Society has great potential in the arena of effective continuing medical education because of the state's generally enlightened approach to education, the well accepted medical schools, the land-grant philosophy and the general positive approach of the Society. I do feel, however, to most effectively serve the people of the state it must move promptly and decisively using the experiences of other state societies, but setting its own guidelines and then acting on them."

Doctor Greenbaum is in charge of continuing medical education at the Michigan State University College of Human Medicine.

U-M Journal Author Favors Program Built on Use of Audits

A brief overview of the CME forces at work today is provided by James C. Sisson, MD, University of Michigan Department of Internal Medicine, in an article, "Shock and Future Shock in Learning and Practice of Medicine," in the January-March, 1973 issue of the *Univeristy of Michigan Medical Center Journal.*

Doctor Sisson wrote:

"Several methods have been designed to continually motivate physicians to more and better learning. Mandatory periodic relicensure or recertification, presumably by written examination, has been proposed by some. Although legislative acts could compel relicensure, such measures will undoubtedly be unpopular and strongly opposed since it is virtually impossible to design a test which adequately measures the day to day competence of a physician.

"In some areas of the country, membership in medical societies and hospital practice privileges have been made contingent upon periodic appearance at postgraduate meetings. As a criterion of a physician's continued learning, attendance records are, at best, highly questionable, especially when achieved under duress."

In evaluating the various approaches, Doctor Sisson voiced support of a plan that would be based on audits of medical records. Such audits, he wrote, "permits a measure of quality of patient care which in turn brings forth specific recommendations for the repair of any detected professional deficiencies. When applied, these methods should motivate learning. However, habits and attitudes become ingrained over the years, and physicians accustomed to a particular life pattern may reject the proposed criteria of competence, even though developed by experts of national reputation, as artbitrary restrictions. It is essential for the success of postgraduate education that the demands for change in patient care be comprehensible and tangible goals, at least for most physicians. The audit should also serve as useful data for peer review. A doctor may be encouraged or perhaps coerced to 'keep up' so that he or she may keep down the criticisms of colleagues, particularly if society membership or staff privilege is at stake."

It's Detroit Again.
The 1973 MSMS Annual
Scientific Session will
be offered Oct. 10-11
at the Sheraton-Cadillac
Hotel in Detroit, following
the House of Delegates
Oct. 7-8-9.

President's page

John J. Coury, MD
MSMS President

I believe in voluntary CME. Do you?

Continuing Medical Education. Let me say at the outset—I believe in it!

It is essential if one is to practice quality medicine!

If you have been checking your mail during the past 20 years, you have probably noticed an ever increasing crescendo of announcements of all types of post-graduate medical courses. If you have attended any of these, you would also realize they are filled to capacity. This is a real tribute to the majority of practicing physicians in our great country—another reason why the American physician, man for man, practices the highest quality of medicine in the world.

With increasing government intervention in the past few years, PSRO, Medicare, Medicaid, etc., plus the creation of all kinds of "Social Engineers," we are hearing a clamor for mandatory, regimented CME. Another yoke around the neck of the practicing physician. Everybody wants to throw away the "whole bushel of apples" because there are a few bad ones in the basket—"the infantile thinking" of most of our society today on most issues.

This message will probably be read by most who don't need it, however their interest may rub off on those who do need it, those who refuse to take advantage of CME. One cannot continue to practice quality medicine if he does not keep astride with the advances of medicine. Those of you who don't are also a yoke around the neck of your colleagues.

I urge you to awaken from your lethargy, take pride in yourself and your profession and improve the quality of your practice.

Stop being the Achilles heel of our profession!

The great majority of your colleagues are doing a quality job—why not join the team?

Many MSMS members will participate in the MSMS Annual Session in Detroit, Oct. 10-11. Will I see you there?

For those who cannot leave their practice because of rural and isolated practices, then educational and medical organizations must take the post-graduate education to them so that these men will not have to abandon their patients during such learning periods.

Lastly, I am unalterably opposed to mandatory, regimented CME for relicensure! There is no profession in our country that continually educates itself—man for man—as does the medical profession!

For the great majority of you who are doing quality work and continually educating yourself, I say "thanks and keep up the good work."

For the small minority of you who won't continually educate yourselves, I say "Stop ruining the 'beautiful basket of apples.' Stop being an anchor on your profession. Take pride in yourselves. Reeducate and improve the care to your patients."

I believe in voluntary CME!

How about you?

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

1973 Annual Session

Two governors, top educational programs on Detroit agenda

One of the most exciting programs ever assembled by MSMS is in store for physicians who will be in Detroit October 7-11 for the annual session of the House of Delegates and the Scientific Session. In addition to conducting the society's business affairs, delegates will have the opportunity to hear speeches by Otis R. Bowen, MD, the governor of Indiana, and Michigan's Gov. William G. Milliken. Doctor Bowen will address the annual MDPAC luncheon on Monday and Gov. Milliken will speak to delegates Tuesday morning.

Delegates will get up to date information and the opportunity to express their views on PSRO activity in Michigan and funding of postgraduate medical education at special meetings Monday afternoon.

After its grand opening Tuesday night, the 1973 Scientific Session will offer physicians 28 different programs keyed to their interests and needs. Particularly high interest is expected in a Wednesday morning session dealing with health care delivery and particularly with regulation from the outside. John B. Bryan, MD, of Royal Oak, coordinator of the scientific program for 1973, is moderator. MSMS specialty sections have arranged many of the programs.

Among out of state guest speakers for the programs are Wallace Rubin, MD, of New Orleans, associate professor of otolaryngology at the Tulane University School of Medicine; Richard G. Lester, MD, of Durham, N.C., chairman, Department of Radiology, Duke University Medical Center, and Phillip E. Bernatz, MD, Rochester, Minn., professor of surgery, Mayo Medical School. The programs run the gamut from acupuncture to urology.

For the first time, a seminar on medical socioeconomics and practice management will be offered. Full details are covered in the advance Scientific Session program mailed to all MSMS members.

All programs are in the Sheraton-Cadillac Hotel.

Must vasodilators and therapy for other diseases come into conflict?

not if the vasodilator is

VASODILAN®

(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Exhibit opening to be 'grand' at 1973 Annual Session

Again this year, as in 1972, Michigan physicians attending the MSMS Annual Session at the Sheraton-Cadillac Hotel, Detroit, will get a preview of the exhibitors' booths by way of a grand opening.

The exhibitors' hall doors will be opened at 6 p.m. Tuesday, Oct. 9, to allow physicians, their spouses and Annual Session guests the opportunity to sample refreshments and exhibitors' displays. The party will officially open the 1973 MSMS Scientific Sessions.

Plans are for the grand opening of the exhibits to be combined with the annual party honoring the newly-named MSMS president-elect. He will be designated this year on Tuesday afternoon at the close of the final meeting of the MSMS House.

A total of 41 exhibits will be displayed during the Annual Session. The leasing of the exhibit space makes it possible for MSMS to present the two-day Annual Scientific Session free of charge to the doctor. MSMS wishes to express its gratitude to each firm who will be presenting displays.

They are as follows:

1973 MSMS Annual Session Exhibitors

Abbott Laboratories
Advance Medical and Research Center, Inc.
Astra Pharmaceutical Products, Inc.
Ayerst Laboratories
Black & Skaggs Associates, Inc.,
  Professional Management
Breon Laboratories, Inc.
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INFORMATION FOR CONTRIBUTORS

1. Address scientific manuscripts to the Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Submit original, double-spaced typewritten copy and two carbon copies or photo copies on letter size (8½ x 11 inch) paper. On page one, include title, authors, degrees, academic titles, and any institutional or other credits.
2. Authors are responsible for all statements, methods, and conclusions. These may or may not be in harmony with the views of the Editorial Staff. It is hoped that authors may have as wide a latitude as space available and general policy will permit. The Publication Committee expressly reserves the right to alter or reject any manuscript, or any contribution, whether solicited or not.
3. Illustrations should be submitted in the form of glossy prints or original sketches from which reproductions will be made by **Michigan Medicine.**
4. Articles should ordinarily be less than four printed pages in length (3000 words).
5. References should conform to *Cumulative Index Medicus,* including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.
6. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.
7. It is understood that material is submitted for exclusive publication in **Michigan Medicine.**
8. Letters and articles for the news section should be sent to the Managing Editor, **Michigan Medicine,** 120 W. Saginaw, East Lansing, 48823, by the fifth of the month preceding the month of publication.

Bobo's back at the big top

After a rheumatoid arthritic flare-up.

Butazolidin® alka   Geigy

Each capsule contains:
100 mg phenylbutazone USP
100 mg dried aluminum hydroxide gel USP
150 mg magnesium trisilicate USP

If it doesn't work in a week, forget it.

Important Note. This drug is not a simple analgesic Do not administer casually Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc) before prescribing and at frequent intervals thereafter Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently Warn patients not to exceed recommended dosage Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy Dosage should be taken with meals or a full glass of milk Substitute alka capsules for tablets if dyspeptic symptoms occur Patients should discontinue the drug and report immediately any sign of fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema A one-week trial period is adequate Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty

Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

Contraindications: Children 14 years or less, senile patients; history or symptoms of G I inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy, blood dyscrasias, renal, hepatic or cardiac dysfunction, hypertension; thyroid disease, systemic edema, stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy

Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers Drug may appear in cord blood and breast milk Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G I tract has occurred The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents Carefully observe patients taking these agents Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid) Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage If edema occurs in patients over sixty, discontinue drug

Precautions: The following should be accomplished at regular intervals Careful detailed history for disease being treated and detection of earliest signs of adverse reactions, complete physical examination including check of patient's weight, complete weekly (especially for the aging) or an every two week blood check, pertinent laboratory studies Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc Cases of leukemia have been reported in patients with a history of short- and long-term therapy The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia

Adverse Reactions. This is a potent drug, its misuse can lead to serious results Review detailed information before beginning therapy Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G I bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G I bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy, CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia, ulcerative stomatitis, salivary gland enlargement (B)98-146-070-H(10/71)

For complete details, including dosage, please see full prescribing information

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

BU 9337

More than sleep.

your choice of sleep medication is wisely based on more than sleep-inducing potential

sleep with relative safety

Chronic tolerance studies have confirmed the relative safety of Dalm (flurazepam HCl); no depression of cardiac or respiratory func was noted in patients administered recommended or higher d for as long as 90 consecutive nights.

In most instances when adverse reactions were reported, they were mild, infrequent and seldon quired discontinuance of therapy. Morning "hang-over" with Dalmane has been relatively infrequent. D ness, drowsiness, lightheadedness and the like have been the side effects noted most frequently, particularly in the elderly and debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

sleep for 7 to 8 hou without need to repeat dosage

No sleep m cation has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia pat given one 30-mg capsule of Dalmane at bedtime, on average: fell asleep within 17 minutes, had fewer n time awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to re dosage during the night.

leep with onsistency

Dalmane has been shown to be consistently effective even during consecutive nights of administration, with no need to increase dosage.

Dalmane (flurazepam HCl) is a distinctive sleep medication—a nzodiazepine specifically indicated for insomnia. It is not a barurate or methaqualone, nor is it related chemically to any other ailable hypnotic.

When your evaluation of insomnia indicates the need for a sleep edication, consider Dalmane—a single entity nonnarcotic, nonrbiturate agent proved effective and relatively safe for relief of omnia.

DALMANE®
(flurazepam HCl)
When restful sleep is indicated

One 30-mg capsule *h.s.*—usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.*—initial dosage for elderly or debilitated patients.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits, and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage, 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE

ROCHE LABORATORIES
Div., Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

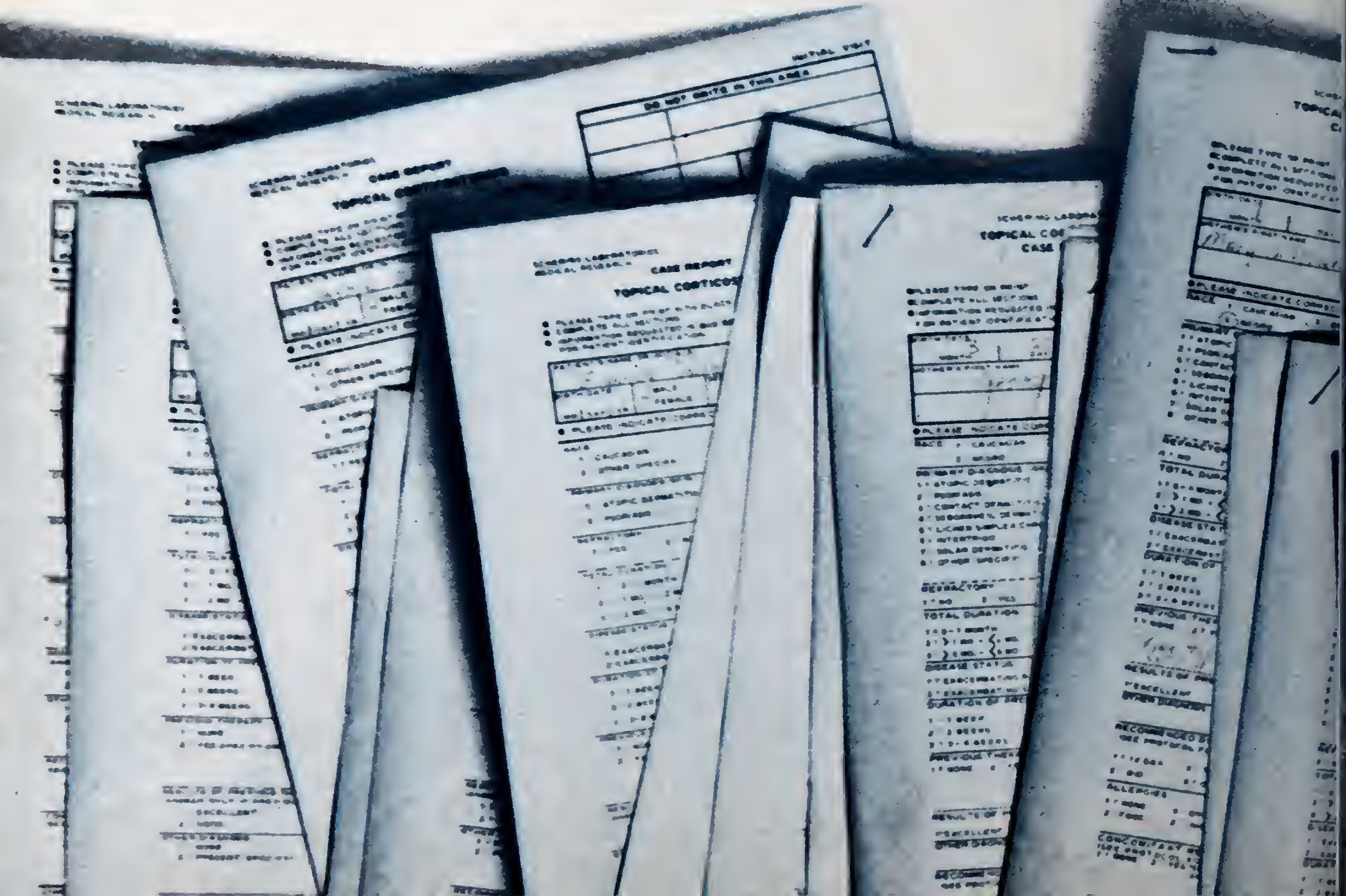
A topical steroid that has clinically succeeded

in study...after study...after study[1-6]

Excellent/good results

85% in psoriasis *(150 of 177 patients)*[1]

92% in atopic ecze *(231 of 251 patients)*[1]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CASE REPORT
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TOPICAL CO
CASE

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Valisone®

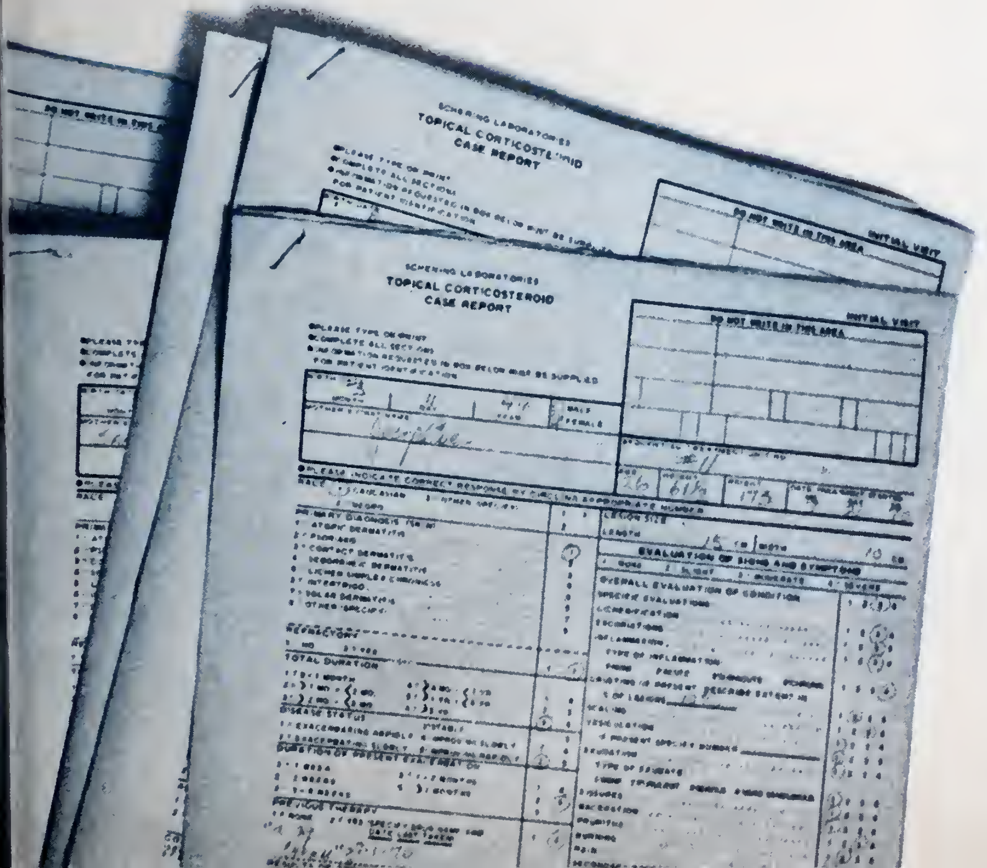
brand of

betamethasone valerate (0.1%) Cream/Ointment

Plus economy *B.i.d. dosage often found effective!*
Available in 5, 15, and 45 Gm. tubes.

96% in contact dermatitis

(81 of 84 patients)[1]



CLINICAL CONSIDERATIONS:

Description VALISONE products contain betamethasone valerate (9-fluoro-11_{β},17,21-trihydroxy-16_{β}-methylpregna-1,4-diene-3,20-dione 17-valerate). Each gram of VALISONE Cream 0.1% contains 1.2 mg. betamethasone valerate (equivalent to 1.0 mg. betamethasone) in a soft, white, hydrophilic cream of water, mineral oil, petrolatum, polyethylene glycol 100 monocetyl ether, cetostearyl alcohol, monobasic sodium phosphate, and phosphoric acid; 4-chloro-m-cresol is present as a preservative. Eac gram of VALISONE Ointment 0.1% contains 1.2 mg. betamethasone valerate (equivalent to 1.0 mg. betamethasone) in an ointment base of liquid and white petrolatum, and hydrogenated lanolin. VALISONE Cream and Ointment contain no parabens.

Indications VALISONE Cream and Ointment are indicated for the relief of the inflammatory manifestations of corticosteroid-responsive dermatoses.

Contraindications VALISONE Cream and Ointment are contraindicated in vaccinia and varicella. Topical steroids are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.

Precautions If irritation develops with the use of VALISONE Cream or Ointment, treatment should be discontinued and appropriate therapy instituted. In the presence of an infection, the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled. If extensive areas are treated or if the occlusive technique is used, the possibility exists of increased systemic absorption of the corticosteroid and suitable precautions shoul be taken. Although topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use in pregnant females has not been absolutely established. Therefore, they should not be used extensively in pregnant patients, in large amounts, or for prolonged periods of time. VALISONE Cream and Ointment are not for ophthalmic use.

Adverse Reactions The following local adverse reactions have been reported with topical corticosteroids: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneform eruptions, and hypopigmentation. The following may occur more frequently with occlusive dressings than without such therapy: maceration of the skin, secondary infection, skin atrophy, striae, and miliaria.

Dosage and Administration Apply a thin film of VALISONE Cream or Ointment to the affected skin areas one to three times a day. Clinical studies of VALISONE have indicated that dosage only once or twice a day is often feasible and effective. AUGUST 1972

For more complete details, consult Scherin literature available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.

References: *(1) Files of Headquarters Medical Research Division, Schering Corporation. (2) Carter, V. H., and Noojin, R. O.: Curr. Therap. Res. 9:253, 1967. (3) Falk, M. S.: Cutis 2:788, 1966. (4) Goldblum, R. W.: Pennsylvania Med. 69:50, 1966. (5) Nierman, M. M.: J. Indiana M. A. 10:1184, 1966. (6) Zimmerman, E. H.: Arch. Dermat. 95:514, 1967.*

SLR-435

ROCHE announces new BACTRIM™

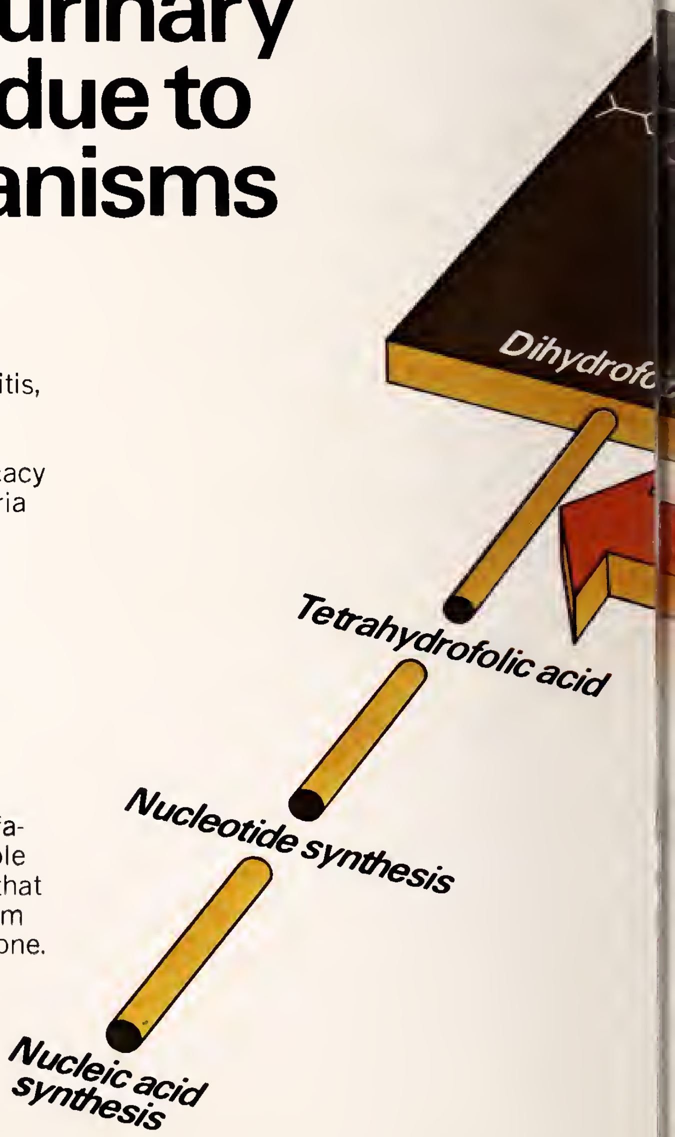
Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

a new type of antibacterial for a two-pronged attack against chronic urinary tract infections due to susceptible organisms

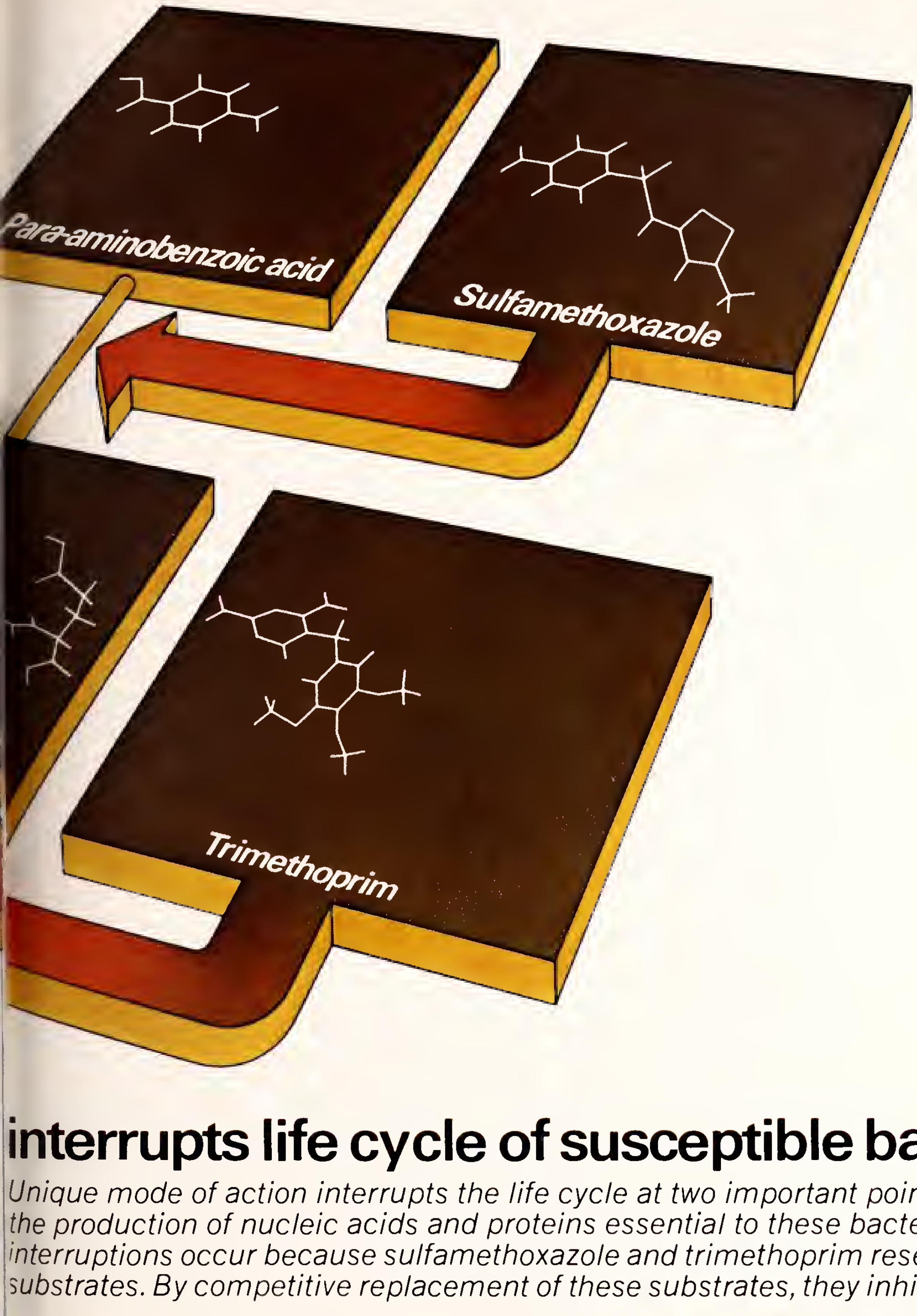
Bactrim is highly effective in the treatment of these infections—primarily pyelonephritis, pyelitis and cystitis, when due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species). This efficacy is related to the unique mode of action against bacteria (see opposite page), an action that, in effect, makes Bactrim a new type of antibacterial.

Bactrim significantly superior to constituents in patients with obstructive complications

In the presence of obstructive uropathy, Bactrim has demonstrated efficacy which is superior to either sulfamethoxazole or trimethoprim alone against susceptible organisms. In addition, *in vitro** studies have shown that bacterial resistance develops more slowly with Bactrim than with either trimethoprim or sulfamethoxazole alone.



*Please note that clinical conclusions cannot be extrapolated from *in vitro* studies.



ROCHE

interrupts life cycle of susceptible bacteria

Unique mode of action interrupts the life cycle at two important points, thereby impeding the production of nucleic acids and proteins essential to these bacteria. These consecutive interruptions occur because sulfamethoxazole and trimethoprim resemble naturally existing substrates. By competitive replacement of these substrates, they inhibit further synthesis.

new **BACTRIM**™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

Before prescribing, please see complete product information on last page of advertisement.

Excellent clinical response in chronic urinary tract infections

A multiclinic, double-blind study* of response to a ten-day course of therapy in 471† patients with chronic urinary tract infections demonstrated the superiority of Bactrim. On the 10th day after initiation of therapy, 91.7% (of 168 patients) showed significant bacteriological response to Bactrim compared with 81.2% (of 144 patients) to trimethoprim and 64.5% (of 155 patients) to sulfamethoxazole. In patients with obstructive complications, 10th day response was 94.8% (of 97 patients) to Bactrim, 72.9% (of 85 patients) to trimethoprim and 58.5% (of 94 patients) to sulfamethoxazole.

Excellent response maintained

Bactrim proved equally impressive in maintaining this bacteriological response. In the above study, after ten-day therapy with Bactrim, 68.4% of patients with chronic urinary tract infections maintained response for up to 42 consecutive days, compared with 59.7% with trimethoprim and 44.4% with sulfamethoxazole. In patients with obstruction, 70.8% of those on Bactrim maintained response for up to 42 consecutive days, compared with 49.4% on trimethoprim and 38.8% on sulfamethoxazole. The figures are particularly remarkable in cases with urinary obstruction—cases regarded as being notoriously difficult to treat.

To date, low incidence of significant side effects

Although Bactrim demonstrated impressive clinical results, it is important to note that the incidence of clinically significant adverse effects was low, mainly nausea and/or vomiting, rash, leukopenia, SGOT increase and creatinine increase.

Bactrim should be given with caution to patients with impaired renal or hepatic function, possible folate deficiency and to those with severe allergy or bronchial asthma. Adequate fluid intake must be maintained. Complete blood counts, urinalyses with careful microscopic examination, and renal function tests should be performed during therapy.

Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.

Usual adult dosage: two tablets every twelve hours for 10 to 14 days; no loading dose required.

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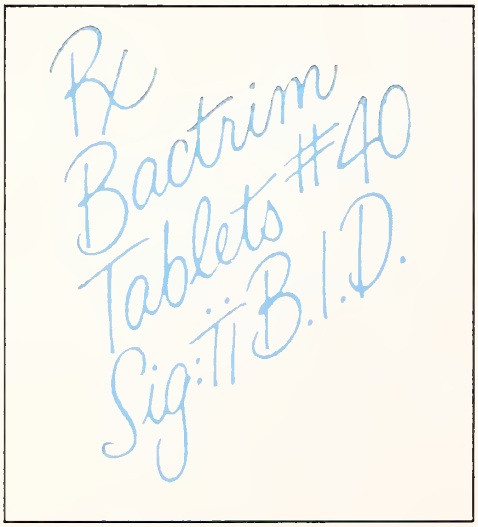
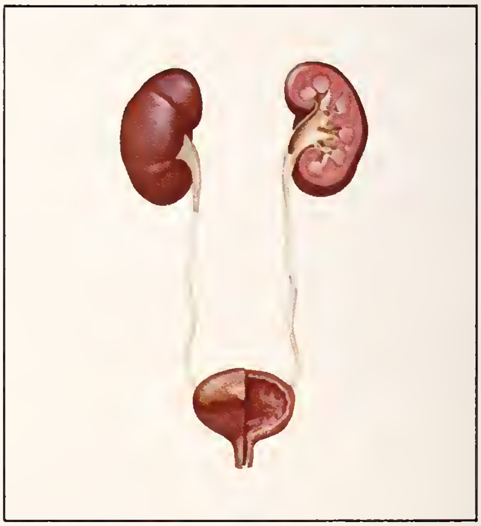
* Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110

† 4 patients not available for evaluation at day 10.



Rx
Bactrim
Tablets #40
Sig: ii B.I.D.



new **BACTRIM**™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, N J 07110

Before prescribing, please consult complete product information on facing page.

Complete Product Information:

Description: Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. It is a white to light-yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is N^1-(5-methyl-3-isoxazolyl) sulfanilamide. It is an almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

Actions: *Microbiology:* Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with *para*-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

In vitro studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

In vitro serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa*. The following organisms are usually susceptible: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis* and indole-positive proteus species.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms
(MIC—mcg/ml)

Bacteria	Trimethoprim alone	Sulfamethoxazole alone	TMP/SMX (1:20) TMP	SMX
Escherichia coli	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
Proteus spp. indole positive	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
Proteus mirabilis	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
Klebsiella-Enterobacter	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

Human Pharmacology: Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. On repeated administration, the steady-state ratio of trimethoprim to sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma decreases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than are the concentrations in the blood. When administered together as in Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis*, and, less frequently, indole-positive proteus species).

***Important note:* Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.**

Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period (see Reproduction Studies).

Warnings: Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombopenia with purpura has been reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

Precautions: Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Reactions: For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

Blood dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

Gastrointestinal reactions: Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

C.N.S. reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

Miscellaneous reactions: Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

Dosage and Administration: Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

How Supplied: Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

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In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

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How Mercurial Diuretics work

By James A. Greene, III, MD
James N. Rivecca MS
Kalamazoo

Since the sixteenth century, when Paracelsus used mercurous chloride, mercurial agents have been known to increase urine flow. Later, administration of the organic mercurial merbaphen (Novasurol), first introduced as an antisyphilitic agent, was found to produce a potent diuretic effect.[1] This led to the introduction of mersalyl (Salyrgan) in 1924. Many other organic mercurials have become available for parenteral administration as diuretics since then. Today many orally active diuretics are in use, however mercurial diuretics are still prescribed by many physicians.

Our understanding of certain aspects of renal function was expanded following the studies of Ussing and Zerahn[2] (1951) who demonstrated that active sodium transport occurs in the isolated frog skin preparation. Their technique consists of mounting the skin between two lucite chambers and adding tracer amounts of radioactive sodium to the bathing media **(Figure 1)**. A unilateral net movement of sodium ions across the tissue was measured in the absence of electrical and chemical concentration gradients. An equal movement of sodium in both directions would be expected if this ion moved passively. Later, Leaf et al.,[3] using this technique, showed that the isolated urinary bladder of the toad, Bufo marinus, also actively reabsorbed sodium, and that this tissue could justifiably be used as a model of mammalian renal tubular tissue, which is difficult to study in isolation. In the toad, the urinary bladder has the ability to reabsorb sodium from the urine as effectively as the renal tubules of man.[3] Studies have been done demonstrating that the isolated toad bladder epithelial cells also respond to aldosterone[4] and antidiuretic hormone (ADH),[5] hormones that regulate sodium and water metabolism in the mammalian kidney. For these reasons many investigators are now using the toad bladder model to study the action of diuretics on the renal tubule.[6,7,8]

Scientific articles

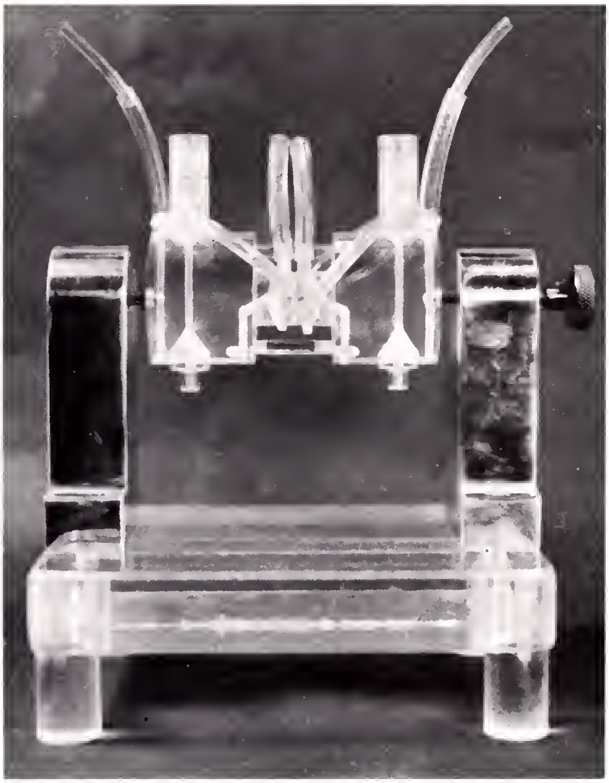
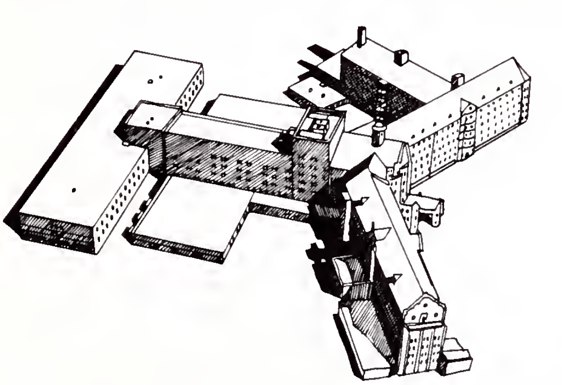


Fig. 1. Apparatus used for Na transport study

The isolated toad bladder preparation can be viewed as a renal tubule which has been opened along its length and stretched between two bathing fluids simulating the urine and renal interstitial



The scientific papers in this issue are all by physicians on the staff of Borgess Hospital, Kalamazoo. The idea of featuring Borgess authors was suggested by hospital leaders and has been carried out in this and last month's issues. Other hospitals who would like to contribute an entire *Michigan Medicine* scientific section are urged to contact the managing editor.

Doctor Greene is director of Michigan Nephrology Center at Borgess Hospital. Mr. Rivecca is director of Nephrology Laboratories at Borgess Hospital.

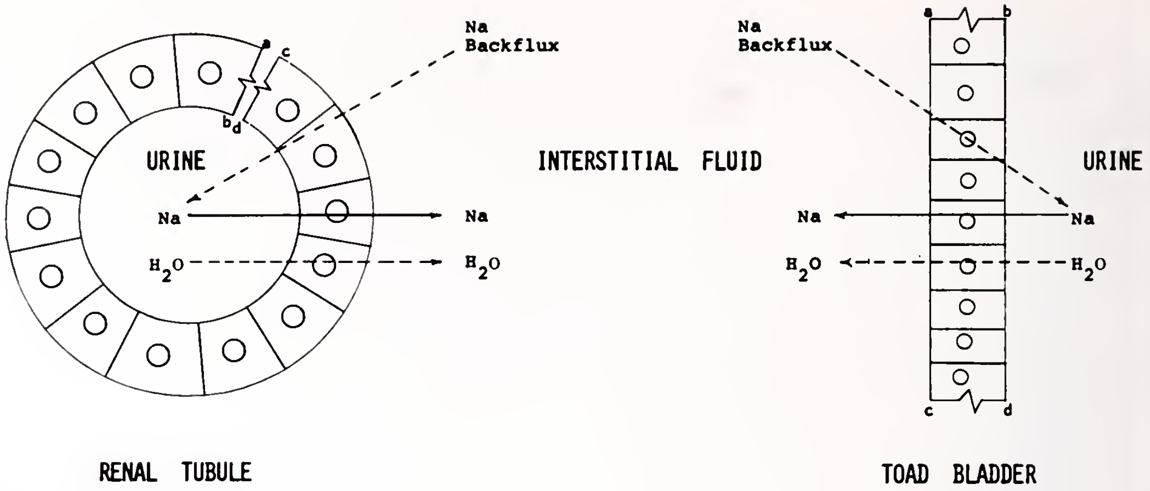


Fig. 2. Similarities between the renal tubule and the toad bladder epithelium.

fluid (**Figure 2**). Sodium is actively transported from the urine to the interstitial fluid via a "sodium pump" and water follows passively due to the osmotic force created by the active reabsorption of sodium. The passive backflux of sodium, i.e. Na movement from the interstitial fluid to the urine, is small because the interstitial side of the cell membrane is relatively impermeable to sodium.

An agent that produces an increased amount of sodium in the urine (a natruresis) could do so either by: (1) inhibiting active sodium reabsorption, or (2) increasing passive backflux of sodium from the interstitial fluid into the renal tubular lumen. Jamison,[6] in 1961, using the toad bladder model, concluded that mercurial diuretics act by depressing active reabsorption of sodium. Taylor[9] suggested that mercurial diuretics reduce active sodium reabsorption by inhibiting sodium-activated ATPase, an enzyme implicated in the active sodium transport mechanism. Herms and Hoffman,[10] 1965, however, found evidence that mercurial diuretics actually increase sodium transport.

Active sodium reabsorption is an "uphill" process requiring energy obtained by oxygen consumption and breakdown of metabolic substrates such as glucose to lactic acid. On the other hand, passive backflux of sodium occurs without expenditure of metabolic energy. The process of active transport of sodium is responsible for approximately 60-80% of the oxygen utilization by the kidney and 30-50% by the toad bladder.[11] In our studies with the toad bladder,[7] we found that mersalyl does not decrease active sodium transport or oxygen consumption. Lactate production is increased. Therefore, in the presence of mersalyl the energy metabolism of the toad bladder may actually be stimulated, thus confirming the finding that active sodium transport is not inhibited. However, we found over a five-fold increase in the passive backflux of sodium. In the kidney this increase in sodium permeability of the cell membrane could account for the natruresis which occurs after administration of mersalyl.

ADH is responsible for a significant amount of water reabsorption by the kidney, as evidenced by the fact that individuals who lack ADH have diuresis (e.g. diabetes insipidus). In the renal distal tubule and the toad bladder,[5] ADH, mediated by cyclic AMP,[12] increases the permeability of the cell membrane to water and this allows a greater quantity of water to be reabsorbed. We have shown that mersalyl prevents ADH and cyclic AMP from stimulating water reabsorption in the toad bladder.[13] By this mechanism mersalyl could cause a diuretic effect in the kidney.

The authors conclude that mersalyl may produce a natruresis in the kidney by increasing the permeability of tubular cells to sodium. The resulting increase in passive backflux of sodium into the renal tubular lumen negates the work done by a viable "sodium pump." The diuretic effect of mersalyl on the kidney is probably due to the inhibition of the effect of ADH and cyclic AMP.

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(Continued on page 620)

Perinatal tips

The following case from the files of the Wayne County Medical Society Perinatal Mortality Study Committee is presented as an aid in continuing education.

By Paul M. Zavell, MD
Detroit

Maternal

This was the sixth pregnancy for this 40 year old white mother with A+ blood type.

Her past pregnancies produced four term infants (all alive and well) and her fifth pregnancy ended in a spontaneous abortion at three months.

At 32 to 33 weeks of this pregnancy she had onset of painless vaginal bleeding following rupture of her membranes and was admitted to the hospital. A placentogram with radioisotopic scanning revealed the placenta in slightly low position but no true placenta previa.

She was placed on strict bed rest but bleeding persisted, only very slightly, however, and also intermittently. Serial hemoglobins showed values ranging from 11 to 11.2 gm with no change in Hematocrit (34.5).

On the fifth day in the hospital labor began spontaneously. An attempt to stop labor by use of I.V. alcohol drip 5% was made but soon abandoned. Twelve hours later (1st = 10 hrs., 2nd = 1 hr. 55 min., 3rd = 5 min.) a small infant was born after face presentation necessitating rotation and low forceps over a mid-line episiotomy.

Prior to delivery on the third hospital day the mother developed signs of cystitis (burning upon urination with 50-70 WBC's and occasional Rbc noted in the urine.) She was treated with Azogantrisin Tablets. Hospital studies showed a negative urine culture and non-reactive VDRL.

Fetal

This four pound two ounce white female infant at birth failed to breathe spontaneously so that bagging was needed until at least two minutes after birth. Following nasal suctioning and gastric lavage of stomach contents (two to three tablespoonsful of bloody amniotic fluid) the infant began to breathe on its own but was deeply depressed and mucousy with flaring of the nares. A large cephalohematoma of the right fronto-parietal region was noted and despite an incubator, heat and oxygen, grunting was noted. The five minute Apgar score was recorded at 6.

At one hour of age the pediatrician first saw the infant and found a mildly cyanotic, premature infant with grunty respirations but fair air exchange. His diagnosis was hyaline membrane disease in a premature infant.

He ordered a chest x-ray (diffuse ground glass appearance with air bronchogram) and Hgb of 14.3 gm with Hct of 44. An arterial umbilical catheter was inserted by seven hours of age for serial gas studies and delivery of appropriate bicarbonate in glucose solution. The gas studies were done every four hours during the first 24 hours after insertion of the catheter. Ph values ranged from an initial 7.33 to 7.41; PCO_2 from initial 55 down to 45; PO_2 from 48 up to 75; O_2 saturation from 87% to 96%. At

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Doctor Zavell is chairman, Perinatal Mortality Study Committee, Wayne County Medical Society, and a member of the Neo-Natal and Hospital Care Committee, Michigan Chapter, American Academy of Physicians.

PERINATAL TIPS/Continued

about 32 hours of age the infant's color had gradually improved and respirations became regular without much retraction.

However, at about 40 hours of age the infant again began to retract noticeably 30 minutes after a feeding of a diluted formula (Similac). She became very cyanotic. Aspiration was feared so that a chest x-ray was done. This revealed "poor aeration throughout but no signs of prior glass ground appearance and no signs of aspiration or pneumonia." Blood studies revealed glucose of 40, Hbg of 6.8 mgm% with Rbc of 1.77 x 10^6, Hct of 18, Wbc of 1800, PMN of 9, Bd of 12, Lymph of 79 and adequate platelets. Type and cross match were drawn and a blood culture was obtained. At 42 hours of age 30 cc of whole blood was given. Peninillin 50,000 units intravenously and Kanamycin (Kantrex) 14 mgm intramuscularly were now started. However, the infant became progressively worse and expired at 47 hours of age. Final clinical diagnoses were "Premature White Female Infant with Hyaline Membrane Disease and Anemia (? blood loss)."

An autopsy was obtained that revealed subarachnoid hemorrhage of the right occiput and base of the skull, widespread evidence of sepsis with positive blood culture for E. Coli and generalized pulmonary atelectasis with mild hyaline membrane disease.

Perinatal Committee Comments

1. Prolonged rupture of membranes, trauma of a difficult delivery, cystitis in mother before birth and prolonged respiratory difficulties after birth all point to possible infection in the infant developing before or shortly after birth. Early cultures and initiation of appropriate antibiotics can be lifesaving (and may have been so here).
2. Although such was not the case here it is worth keeping in mind that pregnancy after age 40 years carries with it increased risks of congenital anomalies in the newborn.
3. The Committee discourages the use of long acting sulfa preparations in a mother shortly before the birth of her infant because of the increased risk that hyperbilirubinemia may develop with resulting danger of kernicterus.
4. A precipitous drop in hemoglobulin should alert the attending doctor to bleeding. A search for the source with corrective measures as indicated (including blood transfusion) should be attempted.

MERCURIAL DIURETICS/Continued

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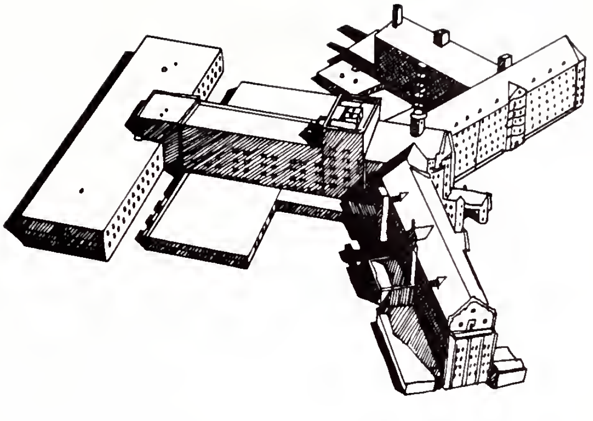
Games patients play



By Doris J. Hoffmann, A.C.S.W.
Kalamazoo, Michigan

In his book, *Games People Play,*[1] Eric Berne, MD, defines a game as "a recurring set of transactions, often repetitious, superficially plausible, with concealed motivation; or, more colloquially, a series of moves with a snare, or a 'gimmick.'"[2]

Games can be differentiated from other behavior by their ulterior quality and their payoff. Games are basically dishonest and are used to justify problems rather than to solve them.

The games described in this paper have been observed in hospital and clinical situations involving chronic renal failure patients. Because of the long-term nature of renal disease and its treatment and the built-in relationship between patient and hospital staff, these patients seem particularly likely to become involved in transactional games.

Frequently, patients are not consciously aware of the games in which they are involved or their motives for playing games, and it is because of this that social workers are often called upon to help patients identify and work through the problems which give rise to the games.

For example, a patient on hemodialysis and currently awaiting a transplant had had considerable difficulty following his diet while in the hospital. The diet is protein-, sodium-, potassium- and fluid-restricted, and needed for weight reduction. When Mr. B. was ready for outpatient treatment, he expressed his concern about following his diet at home, and requested to see the dietitian. When the dietitian discussed the situation with the patient the following exchange took place.

She suggested purchasing special low sodium foods. Mr. B., who appeared on the one hand, very enthusiastic, stated, "yes, but we can't afford them." When the dietitian suggested soaking fresh vegetables to remove potassium he stated, "yes, but my wife works and doesn't have time." When she suggested using a special low sodium cook book which she would provide, Mr. B. again responded, "yes, but my wife doesn't cook with recipes." No matter what was suggested, Mr. B. rejected the idea, and by doing this could prove to himself that the dietitian was inadequate because she couldn't solve his problem.

The game, "Why Don't You, Yes, But" is based on the position that "if you the dietitian, are inadequate, I don't have to do as you say." After proving the dietician inadequate it was easy for Mr. B. to justify why he shouldn't follow any diet, and absolve himself from all responsibility. This is quite clearly a game, the concealed motive being a fear of his illness and inability to accept a diet which is a daily reminder of the illness. The payoff for Mr. B. was not only in continuing to eat as he wished, but also in terms of the continued denial of the illness which was very frightening to him.

The game, "Why Don't You, Yes, But" illustrates the three possible roles a player can take in any game: the victim, the rescuer, and the persecutor. In this game, Mr. B. is a victim of his fear and the dietitian the rescuer who tries to help him. As the game progresses, Mr. B. becomes the persecutor and the dietitian the victim. The elements which define a game: a chain of transactions with an ulterior motive, a payoff, and a switch in role position are all present, and differentiate this episode from a series of straight transactions. The game is clearly quite dangerous for the patient as it could easily result in his death. The patient is currently being helped to accept his illness and hopefully will be able to cope with his fears realistically before he is discharged from the hospital.

Another game which dialysis and transplant patients seem to play with some frequency is "Look How Hard I've Tried." Mr. B. is also quite skillful at this game which is based on the position that, "If I am blameless, you can't punish me." His classic comment to the nurse when caught with a glass of orange juice was "It was on my tray. I thought my diet changed." Basically this game allows Mr. B. to express his anger without guilt about overt aggression. There is again a role change with Mr. B. persecuting the nurse, his victim, and a payoff not only of orange juice, but in maintenance of the patients' identity and self direction.

A favorite game of patients who are being adequately treated with dialysis or who have had renal transplants is "If It Weren't For You." In this

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Ms. Hoffmann is with the Department of Social Services, Borgess Hospital.

game, patients with fears of inadequacy can protect themselves from failure by not becoming involved.

Mr. M., an immature young man whose adolescent development was interrupted because of his chronic kidney disease and subsequent transplant, has not been able to establish any meaningful heterosexual relationships, frequently changes jobs, periodically lives at home with his mother, and always has a multitude of physical complaints which have no medical basis.

Mr. M. has frequently stated his desire to get married, but always adds, "If It Weren't For You and the drugs you give me which make me cushionoid and unattractive," or "If It Weren't For You and regular clinic visits, I could keep a job and afford to get married," or, "If It Weren't For You and your inability to find a cure for my illness, I could do almost anything." Mr. M. is able to deny his fears of getting married and his feelings of inadequacy by blaming others. He obtains secondary gratification from other people because of his condition and avoids situations which are threatening to him.

Patients with chronic kidney disease who are facing dialysis or transplant frequently have a great deal of anger about their condition which is difficult to express directly within the hospital setting where all activity is allegedly directed toward helping the patient. Patients therefore find somewhat devious means for expressing anger as in the game "Now I've Got You, You Dirty Doctor."

In this game the patient awaits some minor slipup by the physician and then vents his rage in an often delighted fashion. The patient can justify his anger because the doctor in fact failed to perform some minor task, and the patient can rationalize that he has a right to be angry under the circumstances. Patients who play this game collect injustices and frequently provoke their victims into slighting them. Variations of this game include "Now I've Got You, You Nasty Nurse and You Terrible Technician."

One patient in our experience was put on a daily exercise program in the physical therapy department to assist in weight reduction and to maintain muscle strength while hospitalized. During one exercise session he apparently pulled a muscle in his shoulder and used this minor injury to express his anger not only toward the physical therapist who had been working with him, but toward the "dirty doctor" who had initiated the program. The anger was in fact related to the patient's illness and his fear of having a transplant. If the staff had not intervened in this situation the patient might have been able to postpone his transplant and therefore avoid the fear, because he refused further physical therapy, and without a reduction in weight, surgery could not be performed.

"Kick Me" and "Blemish" are games frequently played by patients who have decreased feelings of self-worth. This is very common among chronic dialysis patients and the games are usually played to justify or to ward off depression. In the game "Blemish" the patient can ward off depression by proving that other patients' problems are worse than his own. "Blemish" players frequently request information from staff about new patients and show a morbid curiosity about any acutely ill patient. In the game "Kick Me," the patient manipulates others into saying or inferring "you are no good," and can then justify his depression without relating it to its real source. Those we refer to as *"obnoxious"* patients, are generally patients who are playing some form of "Kick Me." One patient was so successful at this game that not only did hospital staff avoid his room, but his roommate requested a change of rooms. The patient could then justify his depression, which in fact related to his illness, without having to solve his real problems of fear.

"Cops and Robbers" is a game which patients frequently play in relationship to their diet, but it can also be played in other situations. The basic position of the game is, see if you can catch me. The player is really hoping to be caught and then reassured of his worth by the staff forcing him to correct his bad behavior. Mr. G. was quite anxious during his six hour dialysis treatments, and frequently asked to have his treatments shortened. Staff, rather than responding to the anxiety, responded to the request by giving technical explanations of the square-meter hour hypothesis. Mr. G. apparently decided to get reassurance by playing "Cops and Robbers." The minute the technician turned his back, Mr. G. would move his arm vigorously in an attempt to dislodge the fistula needles. The secondary gain from this activity was that he frequently succeeded and the treatments were terminated early. When caught moving his arm, Mr. G. seemed pleased and attentively listened to the reprimands. Mr. G. also played "Cops and Robbers" by trying to hide his amphogel in his pocket rather than taking it or by trying to light a cigarette despite the fact that smoking is not allowed in the dialysis unit. By engaging in these various "criminal" activities, Mr. G. was able to obtain reassurance, but he never really got to the point of discussing his fears about the treatments which were causing the anxiety. The thrill of the chase in "Cops and Robbers" certainly made his treatment time less boring, and provided secondary gain in this way.

Despite the fact that all games have elements of exploitation, some games can be considered good because their social contribution outweighs their ulterior motives. For example, the game "Happy to Help" is frequently played by living related kidney donors. In this game the patient may be motivated

MONTHLY SURVEILLANCE REPORT

Cases of Certain Diseases Reported
to the Michigan Department of Public Health
For the four-week period ending July 27, 1973

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

	1973 This 4-Week Period	1972 Same 4-Week Period	1973 Total To Above Date	1972 Total Same Date	Total Cases for 1972
Rubella	71	33	1,769	1,229	1,460
Cong Rubella Syndrome	0	0	1	0	1
Measles	150	105	4,282	1,946	2,353
Whooping Cough	5	11	44	63	116
Diphtheria	0	0	0	1	1
Mumps	84	133	3,835	2,620	3,729
Scarlet Fever & Strep Sore Throat	996	370	14,123	7,648	13,304
Tetanus	1	0	1	1	2
Poliomyelitis (paralytic)	0	0	0	0	1
Hepatitis	259	283	2,210	2,528	4,322
Salmonellosis (other than S typhi)	68	61	362	452	781
Typhoid Fever (S typhi)	0	0	6	5	7
Shigellosis	58	56	343	325	574
Aseptic Meningitis	34	13	105	52	266
Encephalitis	10	10	94	49	108
Meningococcic Meningitis	4	3	36	32	55
H. Influenza Meningitis	3	3	69	45	81
Tuberculosis	114	98	830	1,007	1,609
Syphilis	317	360	2,591	2,896	4,815
Gonorrhea	2,567	1,868	16,371	12,966	24,728

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, MD, Director
Michigan Department of Public Health

to donate a kidney in order to elevate his status within the family or perhaps to absolve his guilt about previous mistreatment of the recipient. In any case the donor and recipient both stand to benefit from the game. The danger, of course, is that the donor may really not want to give his kidney and after surgery may decide to play "Now I've Got You, You Kidney Snatching Surgeon." This kind of game can end in a malpractice suit.

The games which patients play are not unique to patients, but are played by each one of us every day. Patient games are worth examining, however, because of the high, sometimes life and death, stakes which are involved. Generally, patients play games to avoid intimacy or relationships in which their problems can be discussed and solved. Once it is recognized that a patient is engaging in game behavior, one can simply refuse to play the game or gently confront the patient with his behavior. In the first game discussed, "Why Don't You, Yes, But," the patient requested to see the dietitian because of realistic concerns about eating outside of the hospital. The dietitian, instead of making suggestions, could have refused to play the game by asking the patient how he thought he might solve the problem. This attitude would have conveyed a sense of respect for the patient and willingness on the part of the dietitian to enter into a relationship with the patient. The danger in refusing to participate in the game is that the patient could become extremely angry and able to rationalize his anger because he could feel the dietitian was not doing her job.

The second method of preventing games, gentle confrontation, generally is more effective. In the above situation, the dietitian was able to confront the patient by pointing out to him that he didn't really seem interested in solving his diet problems, but that he did seem very worried. By doing this, the dietitian conveyed a real interest in the patient and his problems, and made possible honest communication and relationship. The patient was able to talk with the dietitian about his fears, and eventually was able to work out his diet problems.

Comprehensive patient care demands that staff learn to recognize when patients are playing games, that they learn to deal with the games effectively, and most important, that they provide an atmosphere in which problems can be discussed so that games are not necessary. Games can only justify problems, never solve them.

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Here is MSMS Public Health Committee report which led to support of routine GC culture

The MSMS Committee on Public Health, as previously announced in the *MSMS Medigram* newsletter, recently recommended to the MSMS Council that "the taking of a gonococcal culture, as part of a routine pelvic examination, is considered a standard of care." The Council approved.

"By making the test for gonorrhea a standard of care, the committee is confident that the fear of technical, legal and ethical problems and embarrassment will be overcome," says Louis R. Zako, MD, committee chairman, in a letter to all secretaries of Michigan component societies.

Following is the text of the committee's special report to the MSMS Council, which approved the recommendation for the GC culture as part of a routine pelvic examination:

"The Committee requests The Council to consider a policy statement to the effect that the taking of a GC culture, as part of a routine pelvic examination, is considered a standard of care.

"The U.S. Public Health Service is now recommending that all women of reproductive age be tested for gonorrhea during routine physical examinations and for those who do not get routine physical examinations, a yearly test for gonorrhea, much as they now have Pap smears for cancer. Physicians can easily take specimens for both cervical cancer and gonorrhea in one examination.

"The National Commission on Venereal Disease has recommended widespread programs within government, the schools and organized medicine to stem the epidemic tide of venereal disease.

"A total of 22,259 cases of gonorrhea were reported in Michigan last year, compared with 20,359 in 1970 and 8,372 in 1960. The Michigan Department of Public Health says gonorrhea is No. 1 among all reportable communicable diseases.

"The attempts of many to bring gonorrhea out of the closet of ignorance into open acceptance as a fact of modern life is a commendable one and may eventually help lift the social stigma which has hampered control efforts. The two vital components of gonorrhea control programs are treating contacts of known cases and seeking out asymptomatic carriers. The chief limiting factor in gonorrhea eradication is detection and treatment of the asymptomatic carrier. This generally means the female. The male is likely to develop painful urethritis and seek treatment but most infections, approximately 80% according to most authorities, in females are asymptomatic or the symptoms are minimal.

"Even though there is no legal obligation for the physician to inform parents that their son or daughter has gonorrheal infection which requires treatment, some physicians may feel certain ethical responsibilities to the family depending upon his relationship with them. Many private practitioners will not suggest the test to their patients, unless there appears to be medical indications. Also, many physicians will be reluctant to test women routinely for gonorrhea, unless requested by the patients themselves.

"The Committee strongly urges that physicians be encouraged to give gonorrhea detection tests to their women patients during routine examinations. By making this test a standard of care, the Committee is confident that the fear of technical, legal and ethical problems and embarrassment will be overcome.

COUNCIL ACTION: The Council on June 20, 1973 received this report with thanks and approved it with the following amendments: delete the phrase "and specific consent of the patient need not be obtained" from paragraph one, and delete the word "private" from line 1 of the second paragraph on page 2.

Nuclear pacemaker ready at Beaumont

The first nuclear-powered pacemaker for implanting in a heart patient in Michigan is awaiting surgical placement at William Beaumont Hospital, Royal Oak.

The device arrived at the hospital by air this summer after Beaumont became the first hospital in Michigan and adjacent states authorized by the AEC to participate in a program for expanded use of the new instrument.

"Use of the nuclear pacemakers is still on an investigative basis," explains Gerald C. Timmis, MD, co-chief of cardiology at Beaumont. "Our license authorizes us to implant 10 within the next year."

The first Beaumont patient to receive the nuclear device it yet to be selected. An estimated 10 years of service can be expected from the pacemaker.

The Serumcidality of Clindamycin Palmitate

By Gary Ruoff, MD
James D. Panzer, MD, PhD
William H. Atkinson, MA
Kalamazoo

Introduction

Because of its proven efficacy and bactericidality, penicillin is the drug of choice in the therapy of β-hemolytic streptococcal infections. However, because of the problem of penicillin sensitivity, alternate antibiotics are needed which should be as efficacious as penicillin, as well as bactericidal for the streptococcal organism. In recent years many new antibiotics have been marketed and most recently clindamycin palmitate. Although the clinical efficacy of clindamycin and its parent compound, lincomycin, has been well documented in the therapy of streptococcal pharyngitis, (1-10) its bactericidality has only been demonstrated using strictly *in vitro* methods. It was the purpose of this study to document the serumcidality of clindamycin palmitate in subjects being treated with the drug and where the test organism was that cultured from the subject's own infection.

Methods

Twenty-seven subjects who presented with symptoms of pharyngitis and who had Group A β-hemolytic streptococcal organisms demonstrated by throat culture were selected. These subjects received clindamycin palmitate according to the package insert dosage (10 days therapy) and were asked to return on the third day after the start of therapy at which time a serum sample was taken. This serum sample, along with the original culture, was sent to the laboratory and the serumcidality determined according to the Schlichter method, as described in *Gradwahls Clinical Laboratory Methods and Diagnosis*, 6th edition.

In essence this is determining the highest dilution of the patient's serum in which no viable organisms can be demonstrated and where the test organism is that cultured from the patient. Both Minimum Inhibitory Concentration (MIC) and Minimum Bactericidal Concentration (MBC) are determined.

TABLE 1
Serum Antibiotic (Schlichter) Levels

Patient Name	Organism Recovered	Bacteriostatic* Dilution	Bactericidal** Dilution
MH	Beta Strep	1:64	1:64
GH	Beta Strep	1:64	1:32
BD	Beta Strep	1:128	1:128
DS	Beta Strep	1:64	1:64
TW	Beta Strep	1:32	1:32
PG	Beta Strep	1:128	1:128
SM	Beta Strep	1:64	1:64
RW	Beta Strep	1:16	1:16
MB	Beta Strep	1:64	1:32
JR	Beta Strep	1:8	1:2
MM	Beta Strep	1:64	1:64
TD	Beta Strep	1:4	1:2
DF	Beta Strep	1:128	>1:128
AJ	Beta Strep	1:64	1:32
CL	Beta Strep	1:128	1:128
JS	Beta Strep	1:128	1:64
SG	Beta Strep	1:64	1:32
KW	Beta Strep	1:32	1:16
TC	Beta Strep	1:16	1:8
EN	Beta Strep	1:8	1:4
CB	Beta Strep	1:16	1:16
SS	Beta Strep	1:32	1:32
JM	Beta Strep	1:64	1:32
JJ	Beta Strep	1:16	1:16
KJ	Beta Strep	1:32	1:32
ME	Beta Strep	1:16	1:8
AS	Beta Strep	1:64	1:32

*Bacteriostatic dilution of serum is the highest dilution of serum that completely inhibits growth.

**Bactericidal dilutions of serum is the highest dilution of serum in which transfers show no growth.

All subjects returned 14 days after the start of therapy at which time they were evaluated clinically and a throat culture was taken to insure that the organism had been eradicated.

Results

The results of the Schlichter Test for the various patients are given in **Table 1.** It can be seen that excellent levels were obtained in all of the subjects except two in which good levels were obtained (bactericidal dilution of equal to or greater than 1:4 is considered serumcidal).

(Continued on page 626)

Doctor Ruoff is in private practice at the Westside Family Medical Center, PC, Kalamazoo. Doctor Panzer is medical research chief of the Infectious Disease Products Division of the Upjohn Company, where Mr. Atkinson is a medical marketing associate in infectious disease research.

All subjects were clinically and bacteriologically cured of their streptococcal disease at the 14-day evaluation.

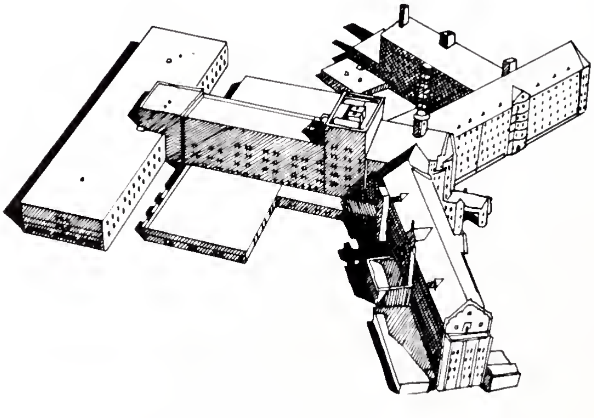
Discussion

Although no methodology exists for the determination of bactericidality of any drug (including penicillin) under strictly *in vivo* conditions, the Schlichter Test is perhaps as close as one can come since it involves the drug distributed in a given patient's serum as affecting the pathogen responsible for the patient's disease. In this study excellent Schlichter levels were found in 92% (25 of 27) of the patients which attests to the serumcidality of clindamycin palmitate.

Since, as already discussed, the efficacy of clindamycin palmitate in streptococcal disease has been adequately demonstrated, and since this study demonstrates its serumcidality against the streptococcal organism, it is the opinion of the authors that clindamycin is a most suitable alternate to penicillin in the therapy of β-hemolytic streptococcal disease.

Summary

Excellent Schlichter levels (batericidal dilutions) were obtained in the majority (92%) of clindamycin palmitate treated subjects who had bacteriologically demonstrated β-hemolytic streptococcal pharyngitis disease.



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The role of occupational therapy in the general hospital setting

By William G. Tucker, MD
Carole A. Wagnitz, OTR
Kalamazoo

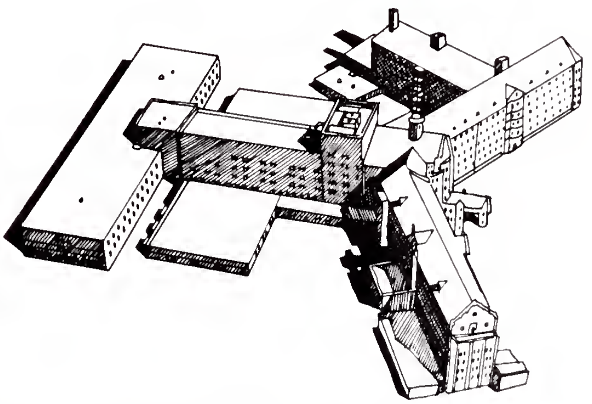
The Midwest Oncology Center at Borgess Hospital is a forty-three bed unit in the general hospital setting. It is a progressive care unit for inpatient treatment, as well as a center for outpatient treatment and research. The main type of care offered to all oncology patients is that of a total team approach to rehabilitation of the patient himself to meet his varying physical and psychological needs. Once diagnosed, the patient may be treated with several forms of therapy, including surgery, radiation, or chemotherapy. Any or all of these specific modes of treatment may be utilized during the course of the disease. A special laboratory has also been developed which is concerned with research and analysis in chemotherapy.

Very little has been written in the occupational therapy or other medical literature concerning treatment of the terminally ill. By terminal, the staff at Borgess means an illness which may eventually cause death, not one which is immediately labeled as such. According to Willard and Spackman,[1] malignancies such as cancer and sarcoma merit only a brief, general paragraph in a wide summary of the objectives and functions of occupational therapy. In this discussion they speak only of long-term hospitalization, effects of disease, and adjustment to prognosis. Occupational therapy, however, must be concerned with more than what cancer does to the body, since the entire concept of occupational therapy and rehabilitation emphasizes ability rather than disability. Therapists and physicians must remember that a terminal illness needs support from all sides.

According to Crane,[2] as cited in *The Dying Patient,* each patient reacts differently to dying. One reaction is "social death." Unable to interact meaningfully with anyone, the person appears disorganized and perceives himself "as good as dead" with no further function in a social role. He feels isolated, meaningless, and in this most acute form, may induce death sooner than it might otherwise occur. The nature of response to the knowledge of terminality varies with the individual person and necessarily affects the attitudes of medical personnel involved with his treatment. Kubler-Ross[3] emphasizes that we must not "give up" on any patient, especially those who appear beyond medical help. If we do, he may give up hope of remission, and future medical help may not be effective simply because he does not have the desire or spirit to continue trying. The following is a case history of a patient at Borgess who was not allowed to give up hope, and was referred to occupational therapy to encourage a desire to be independent despite some true medical problems.

Mrs. H., a 62 year old white female, was admitted to the Midwest Oncology Center, Borgess Hospital on 11/29/71. Her past history was significant in that she had had a radical mastectomy in 1955. In 1960, the patient had a bilateral oophorectomy and in the following ten years had had two biopsies, one from the chest area which was negative and two positive supraclavicular nodes. In August of 1971, the patient was started on estrogens. At the time of admission, she was complaining of nausea, vomiting, polyuria, polydipsia, and low back pain. She had not been out of bed for the preceding three months. Her history and physical examination at this time was significant in that she was markedly confused and disoriented as to time and place. She was unable to explain or discuss her symptomatology. She had areflexia and showed marked wasting.

On 11/20/71, her serum calcium was 16 mg%. She was treated with Prednisone at 100 mgs. p.o. per day and IV's were run at four liters per day. On 12/3/71, her serum calcium was down to 13 mg%



Ms. Wagnitz is director of the Occupational Therapy Department at Borgess Hospital, where Doctor Tucker is director of The Midwest Oncology Center.

and on 12/6/71, her serum calcium was down to 10.8 mg%. Following this, the serum calcium remained normal. As the calcium decreased, the patient became more alert. The nausea and vomiting ceased, the patient was less anorexic and we were able to consider the overall pattern of the disease. She had multiple compression fractures of the cervical and the thoracic, as well as the upper lumbar spine. She had far advanced osteolytic metastatic lesions of every bone in the adult bone survey involved. Her alkaline phosphatase was off the chart on the Profile 12 and the LDH was at 550 and the SGOT showed minimal alteration from normal. At the time of admission, her BUN was 57 and this by 12/3/71 had increased to 76 and then it started its slow decline until 12/31/71 when it was 22. Initially, her uric acid was quite markedly elevated at 10.5 and this became normal just with hydration. On 12/6, it was 7.2.

On 12/14/71, the patient was started on Cytoxan 50 mgs. p.o. b.i.d., Oncovin at 2.0 mgs. acute IV, 5-flourouracil at 500 mgs. acute IV, Prednisone at 15 mgs. t.i.d. The Methotrexate was not added to the combination at this time because of the renal problem and as the BUN approached normal, she was placed on Methotrexate in this combination.

Her physical state on 12/14/71 was that of a markedly debilitated individual and she had no pyschological drive to survive. She was alert, but not able to feed herself, wash, or perform any manual functions. The nursing care at this stage of her disease was complete. She had very marked muscle wasting which was generalized. On 12/15/71, the patient was referred to occupational therapy, and at this stage, she was placed manually in a chair three times a day for her meals. By 12/20/71, the patient was given a walker and 1/3/71, was discharged to home. At discharge, she was able, with help, to get out of bed and could get to the bathroom with a walker, a distance of about 15 feet.

At Borgess, occupational therapy is directly involved with treatment of patients such as Mrs. H., especially toward the goal of maximum independence in self-care and daily living activities. Mrs. H. needed to be stimulated and encouraged toward the goal of feeling useful and a functioning person in her particular social role. Upon initial evaluation by the occupational therapist, the patient was not performing daily tasks, as she was bedridden with her husband waiting on her 24 hours a day. General physical activity tolerance was poor, with pain and weakness in both upper and lower extremities, as well as trunk. Quadriceps were weak bilaterally, resulting in poor ambulation and stair-climbing ability. Post-radical mastectomy, the right upper extremity lacked approximately 60° range of motion on extension and abduction at the shoulder, and was especially weak even within active range. Sitting tolerance was initially 15 to 20 minutes. She was experiencing difficulty in transfers from bed to chair, chair to walker, and walker to toilet. The patient was not helping with any household tasks, dressing herself, bathing, or eating independently. Mr. H. fostered this attitude of dependency by insisting that she rest and not exert herself.

Mrs. H. was psychologically as well as physically debilitated. The patient was willing to accept severe limitations in function, and indeed appeared to lack motivation for rehabilitation. The occupational therapist then demonstrated various ways in which her household tasks could be adapted to her limitations, such as sitting to iron, wash dishes, prepare meals, etc. Although the patient was resistant to these suggestions originally, she attempted them at home, and was encouraged by her husband and family per the therapist's request. After two weeks of outpatient occupational therapy, she was able to assist in all the above mentioned activities, and could be left alone for an hour or two at a time. Functional, meaningful activities were assigned during outpatient sessions and at home to achieve the goals of upper and lower extremity muscle strengthening, increased coordination, and improved sitting and standing tolerance. The ability to see concrete results of her activity appeared to encourage maximum effort on the patient's part.

The graded activity, one to one therapeutic rapport of encouragement, and the ability to see herself in a functioning social role despite her limitations were some of the benefits of occupational therapy for Mrs. H. She was able to perform all daily activities independently upon discharge following 10 outpatient treatment sessions. The patient required minimal assistance in climbing flights of stairs, lifting heavy objects, and getting into or out of the bathtub. She was independent enough to be left alone for a full day, prepare meals, and was functioning at a normal level in the community. She continues to be a contributing member of her family and society at 12 months post discharge from occupational therapy.

In the case of Mrs. H., aside from the benefit of showing significant physical and mental improvement, some financial assumptions can be made. Fewer readmissions to the acute care hospital were necessary as well as decreasing the possibility of admission to an extended care facility. Mr. H. did not himself become "run down" and require care, nor have to hire outside help to care for his wife. The savings through such therapy are incalculable. The physicians weigh the actual cost of treatment against the direct benefits. Occupational therapy may well be dollars spent now which can save a patient hundreds of dollars in the future.

In dealing with the total rehabilitation of the oncology patients at Borgess, occupational therapy has proved to be of significant benefit in their long-

msms action

MSMS issues new guide for teachers on smoking/health

This month MSMS is distributing 4,000 copies of a new curriculum guide for teachers about smoking and health.

The guide was developed under the leadership of the MSMS Committee on Public Relations and funded by a special allocation of the MSMS Council as a major public service for this fall.

The booklet, entitled "Smoking and Its Relationship to Health and Disease," is an updated version of a booklet published in 1964 by the Michigan Council on Smoking and Health. At the request of MSMS, it was revised by Donald J. Breckon, Associate Professor of Health Education at Central Michigan University.

Publication and distribution of the guide is part of a special MSMS program to educate the public about health hazards related to smoking cigarettes. The program is directed in particular toward young people.

Along with copies of the guide, schools will be receiving 50,000 copies of an AMA leaflet, "The Cigarette—A Dubious Companion," to be given to students. These leaflets also are available to physicians who would like to distribute them to patients. Yellow "Thank You for Not Smoking" posters also are available from MSMS.

In revising the guide, Mr. Breckon noted that while some schools now are treating tobacco along with alcohol and drugs in classwork dealing with substance abuse, there continues to be a critical need for curriculum materials dealing specifically with cigarette smoking as a health hazard.

The 1973 edition of the guide includes materials for teachers of fourth through 12th grades. The initial MSMS distribution will be to junior high schools because studies have shown that experimentation with tobacco frequently begins in young adolescence.

Any physician who would like materials on smoking and health may contact the MSMS Communication Department.

OCCUPATIONAL THERAPY/Continued

range independence. Occupational therapy can prolong productive months without extreme family dependency. Several patients have experienced a shortened hospital stay, with extended periods of independence at home following inpatient or outpatient occupational therapy. The ultimate goal of occupational therapy, the oncology unit, and rehabilitation at Borgess is the promotion of the individual patient's feeling of purposefulness and independence in their life functions, whatever the limitations.

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Michigan medical assistant is candidate for AAMA office

Medical assistants from Michigan will promote the candidacy of Betty Lou Willey of Port Huron for president-elect of the American Association of Medical Assistants. A former president of the Michigan unit of AAMA, she long has been active in the national organization and serves as a AAMA-Michigan representative on the MSMS Committee on Public Relations.

Health care legislation, shock trauma, and computerized medicine are on the program of the 17th annual AAMA convention, in Washington, D.C., October 23-27.

The AAMA is a national organization of 15,500 medical assistants. Its program of continuing education includes an annual certification examination offered in nearly 70 test centers across the country. The AAMA also collaborates with the American Medical Association in evaluating medical assistant programs in order to establish and maintain curriculum standards. Currently there are 48 accredited programs.

State Board's figures show this distribution of Michigan's MDs

The following statistics are taken from the Michigan State Board of Registration in Medicine Report of 1973 Annual Re-Registrations, as of March, 1973. Statistics for every fifth year are printed to show changes. Copies of the yearly figures are available from MSMS.

County	1970 Population	MDs Registered		
		1963	1968	1973
Alcona	6,943	1	-0-	2
Alger	8,370	5	5	5
Allegan	65,781	21	27	28
Alpena	30,373	21	28	26
Antrim	12,055	4	3	4
Arenac	10,570	1	3	3
Baraga	7,534	1	4	6
Barry	37,858	16	15	16
Bay	116,628	86	91	84
Benzie	8,356	6	3	5
Berrien	161,400	109	112	132
Branch	36,396	30	29	29
Calhoun	140,061	135	146	132
Cass	42,681	12	10	7
Charlevoix	16,131	11	7	8
Cheboygan	16,027	7	8	9
Chippewa	31,910	19	20	20
Clare	15,680	4	6	4
Clinton	48,555	17	11	8
Crawford	6,357	5	8	9
Delta	35,265	25	23	23
Dickinson	23,500	27	28	30
Eaton	68,352	19	22	16
Emmet	17,518	30	42	62
Genesee	441,666	321	331	367
Gladwin	12,747	5	4	4
Gogebic	20,116	13	13	11
Grand Traverse	38,359	66	82	95
Gratiot	38,731	23	22	29
Hillsdale	36,599	17	17	13
Houghton	34,233	21	26	20
Huron	33,418	16	20	20
Ingham	256,567	246	296	375
Ionia	45,632	25	22	19
Iosco	24,161	5	5	16
Iron	13,678	11	11	7
Isabella	43,769	25	29	35
Jackson	142,422	128	110	117
Kalamazoo	199,287	216	242	313
Kalkaska	5,726	2	3	2
Kent	408,234	433	440	523
Keweenaw	2,166	-0-	1	-0-
Lake	5,177	2	3	5
Lapeer	51,736	24	24	20
Leelanau	10,586	1	1	4
Lenawee	80,220	55	60	62
Livingston	58,666	27	27	28
Luce	6,693	19	14	12
Mackinac	9,501	7	6	5
Macomb	620,478	153	238	327
Manistee	19,788	15	15	17
Marquette	63,645	45	56	70
Mason	22,171	17	17	26
Mecosta	27,076	10	13	14
Menominee	23,974	12	10	10
Midland	63,003	53	60	74
Missaukee	7,001	2	2	3
Monroe	117,625	43	43	50
Montcalm	38,851	23	19	21
Montmorency	4,757	1	-0-	-0-
Muskegon	156,077	124	122	124
Newaygo	27,391	18	13	11
Oakland	900,691	667	992	1,551
Oceana	17,660	9	6	9
Ogemaw	11,153	7	8	4
Ontonagon	10,335	7	4	6
Osceola	14,673	4	4	3
Oscoda	4,468	3	1	5
Otsego	10,013	9	7	10
Ottawa	127,468	73	75	93
Presque Isle	12,486	2	3	2
Roscommon	8,944	5	6	8
Saginaw	217,787	168	175	193
Sanilac	34,505	15	17	19
Schoolcraft	8,092	5	6	5
Shiawassee	62,957	33	32	32
St. Clair	118,776	72	80	87
St. Joseph	46,713	31	28	34
Tuscola	48,285	22	17	15
Van Buren	55,182	32	27	29
Washtenaw	230,128	642	756	1,033
Wayne	2,642,348	3,083	3,049	2,714
Wexford	19,295	20	18	20
	SUBTOTAL	7,746	8,379	9,468
OUT OF STATE		2,092	2,786	3,350
	TOTALS	9,838	11,165	12,818
MILITARY (Exempt)		339	665	523
FOREIGN (Missionaries, Peace Corp., etc.)				79

MSMS receives gift of sapling from Tree of Hippocrates

Physicians visiting the Greek Island of Cos rarely miss seeing the famed Tree of Hippocrates, reputed to be 2,500 years old. It is said that the father of medicine gathered his students under the branches of the *Platanus Orientalis,* known more commonly as a sycamore or plane tree, to talk of specific remedies for specific causes and the ethics of the physician.

Recently a bit of the Golden Age of Greece came to the MSMS headquarters in East Lansing with the delivery of an unusual gift for MSMS President John J. Coury, Jr., MD: a sapling grown from a seed from the Tree of Hippocrates.

Presented in a Grecian urn that was included in the gift from the Schering Corporation, the sapling stands about 2 feet tall and is sprouting new leaves. The two-year-old tree has been planted in a sheltered place on the MSMS headquarters grounds. The tree is expected to grow to 12 to 14 feet in six years.

The Schering gift to MSMS came in its nationwide program to distribute the trees to medical organizations. The company purchased the trees to help support the International Hippocratic Foundation, which is seeking funds to erect a building for gatherings of physicians on a historic site that already has been set aside on the Island of Cos.

For many years the idea of distributing saplings from the tree as mementos throughout the medical world was impractical because only a miniscule number of the seeds from the tree are fertile. But, about ten years ago, scientists at the University of British Columbia developed an X-ray process for determining which seeds would germinate.

MSMS Director Warren F. Tryloff (right) accepts the gift of a sapling grown from a seed from the famed Tree of Hippocrates on the Island of Cos from George A. Karaganis (center), division manager for the Schering Corporation, and Arden Bancroft, professional representative of the international pharmaceutical firm.

The sapling grown in the nursery of the University of British Columbia's forestry unit was presented to MSMS in July by George A. Karaganis, of Grand Rapids, Schering Corporation division manager, and Arden Bancroft, Schering professional representative in Lansing. Warren F. Tryloff, MSMS director, accepted the tree in behalf of Doctor Coury.

Jeanne Smith

ABA hears report of mediation for malpractice cases

An experimental mediation program has resulted in "more expeditious" disposition of medical malpractice cases in New York City, members of the American Bar Association were told at their annual meeting recently.

Mediation panels have resolved 30 per cent of their cases since the program was established for Manhattan in the fall of 1971, according to a New York City attorney. Ultimate settlement of at least an equally large percentage of cases was precipitated by the panels' action, he added.

Each mediation panel, he said, is comprised of three persons: a judge, a physician who is expert in the specialty of medicine involved in the case, and an attorney whose expertise lies in the area of litigation.

The lawyer offered these observations:

"Sixteen major specialities encompassing a number of subspecialties were involved in the cases during the initial period. This has proved to be representative. Of those, the specialties involving the largest number of cases were surgery, orthopedics, internal medicine and obstetrics, and gynecology, in that order.

"The amounts of settlements have varied widely. During the initial and, as it turned out, representative year, the average settlement figure was $33,748.21 and the median figure was $14,000."

Socio-economic

AMA report shows changes in numbers of MDs in specialties

By John Anthony, Chief
MSMS Bureau of Economic Information

The latest edition of the AMA's Center for Health Services Research and Development publication, *Distribution of Physicians in the U.S., 1971,* discloses significant increases in certain specialty groups in Michigan since 1970, and substantial decreases in others.

The number of Michigan physicians in neurological surgery increased 16.5%, while those in internal medicine went up 15.9%. Other increases include doctors in radiology (13.7%), pediatrics (12.8%), urology (11.4%) and anesthesiology (10.5%).

While these specialties saw their numbers rise more than 10%, two decreased by that amount. There were 12.3% less allergists in Michigan in 1971 and 12.2% less gastroenterologists.

Two very encouraging figures were those of the number of interns and residents in the state. There were 9.4% more interns and 10.0% more residents in 1971 than in 1970.

MICHIGAN PHYSICIANS

	As of 12/31/70	As of 12/31/71	Percent Change
TOTAL PHYSICIANS	10,982	11,454	4.3%
Patient Care			
Office-Based Practice	6,586	6,776	2.9
Hospital-Based Practice			
Interns	447	489	9.4
Residents	1,747	1,921	10.0
Full-Time Physician Staff	735	761	3.5
Other Professional Activity			
Medical Teaching	177	195	10.2
Administration	337	347	3.0
Research	274	250	−8.8
Other	70	62	−11.4
Not Classified	11	81	636.4
Inactive	598	572	−4.4

MICHIGAN PHYSICIANS ALL PROFESSIONAL ACTIVITIES INCLUDING INTERNS & RESIDENTS

	As of 12/31/70	As of 12/31/71	Percent Change
General Practice	1,795	1,732	−3.5%
Medical Specialties	2,406	2,672	11.1
Allergy	73	64	−12.3
Cardiovascular Diseases	178	170	−4.5
Dermatology	144	146	1.4
Gastroentoerology	49	43	−12.2
Internal Medicine	1,349	1,563	15.9
Pediatrics	562	634	12.8
Pulmonary Diseases	51	52	2.0
Surgical Specialties	3,132	3,329	6.3%
General Surgery	1,149	1,238	7.7
Neurological Surgery	79	92	16.5
Obstetrics & Gynecology	799	838	4.9
Ophthalmology	330	343	3.9
Orthopedic Surgery	267	284	6.4
Otolaryngology	159	162	1.9
Plastic Surgery	54	55	1.9
Colon & Rectal Surgery	32	30	−6.2
Thoracic Surgery	79	82	3.8
Urology	184	205	11.4
Other Specialties	3,040	3,068	.9%
Anesthesiology	296	327	10.5
Child Psychiatry	81	77	−4.9
Diagnostic Radiology	43	44	2.3
Neurology	82	84	2.4
Occupational Medicine	154	145	−5.8
Psychiatry	716	782	9.2
Pathology	352	376	6.8
Physical Medicine & Rehabilitation	45	42	−6.6
Public Health	74	78	5.4
Radiology	401	456	13.7
Therapeutic Radiology	30	28	−6.6
Other Specialty	260	250	−3.8
Unspecified	506	379	−25.1

Family practice exams Oct. 20-21

The American Board of Family Practice will give its next two-day written certification examination on Oct. 20-21 in various centers throughout the United States. Information regarding the examination may be obtained by writing Nicholas J. Pisacano, MD, Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex No. 2, Room 229, Lexington, Ky. 40506.

AMA has pamphlets on health care for poor

Three new pamphlets on free clinics, health outreach and health care of the poor are available free from the Department of Community Health of the AMA. The three are "Statement on Free Clinics: 1972;" "Statement on Health Outreach," and "Committee on Health Care of the Poor, Progress Report," all prepared by the Council on Medical Service and adopted in November, 1972, by the AMA House of Delegates.

Review these questions and save yourself a liability suit

A list of helpful questions for the physician to ask himself as an aid in avoiding professional liability lawsuits is presented here, as drawn up by R. Crawford Morris, LL.B., and Alan R. Moritz, MD.

The questions first appeared in "Doctor and the Patient and the Law," Fifth edition, The Mosby Co., St. Louis, Mo. They appear here with the permission of the authors, the publisher and the Schering Company, which first excerpted them in the *Physician's Legal Brief* newsletter.

Here are the questions:

- Are the cases I accept within my professional qualifications to handle?

- Do I care for every patient with proper attention to the requirements of good medical practice?

- Am I aware of the danger of over-optimism in prognosis?

- Do I know the significance of the statute of limitations?

- Do I obtain a complete x-ray record of every case presenting even a suspicion of bone or joint injury?

- Do I obtain legal and specific consent to operation, hazardous treatment, and autopsy?

- Are my records such that I would not be embarrassed and prejudicially affected by their presentation in court; are they kept in such a way as to give the maximum possible protection in event of suit?

- Do I take special action in case a patient fails to follow instructions or discontinues treatment prematurely?

- Do I secure consultation, protective to both patient and physician, in a doubtful case?

- Am I careful to give full and understandable instructions to the patient and to those caring for the patient?

- Do I routinely make full use of all indicated laboratory aids in diagnosis and treatment?

- Do I notify my patients if I am going away and arrange for their care during my absence? Am I available to respond to calls from my patients or, if I am not, do I have a qualified substitute on call?

- Do I obtain expert advice, at once, whenever the attitude of the patient or the patient's family suggests the possibility that charges of *negligence* may be made? Do I know the necessity in such circumstances of refraining from making any statement, oral or written, either to the patient or to the patient's attorney, until I have secured legal advice?

- Is my professional apparatus kept in the safest condition possible?

- Am I technically qualified to use x-ray, diathermy, and other modalities and instrumentalities which I employ?

- Do I fully realize my responsibility for the negligent acts or omissions of a partner? An employee? An assistant? An associate? A substitute?

- Do I know when I may be responsible for the negligent acts or omissions of an intern or hospital nurse? Or for injury resulting from the use of defective hospital equipment?

- Have I some understanding of the doctrine of *res ipsa loquitur* as applicable to professional liability cases?

- Do I refrain from adverse criticism of the professional care rendered by other physicians?

- Do I know the danger of giving prescriptions by telephone? Do I realize that if a mistake occurs in a telephoned prescription, I may be held liable?

- Am I aware of the desirability of using care in formulating reports required in the event that a patient comes under a workmen's compensation act? Do I know that such reports may be utilized in the event of a professional liability suit arising in the case?

- Do I know that I face the same hazard in the case of an industrially injured and compensated patient, or in the case of a charity patient, as in that of a private, paying patient?

- Do I seek legal advice before testifying at an inquest in connection with a case upon which I have been in professional attendance?

Michigan mediscene

Sept. 10-11—26th Annual Conference on Aging, "Women—Life span challenges," sponsored by U-M and WSU Institute of Gerontology, contact: The University of Michigan Extension Service, 412 Maynard St., Ann Arbor, 48104

Sept. 19—The Council, MSMS headquarters, contact: Warren Tryloff, director

Sept. 19-22—District V meeting, The American College of Obstetrics and Gynecology, The Pantlind Hotel, Grand Rapids, contact: Lee B. Stevenson, MD, Henry Ford Hospital, Detroit

Sept. 20-23—Regional meeting, American College of Physicians and Michigan Society of Internal Medicine, Otsego Ski Club, Gaylord, contact: Muir Clapper, MD, WSU School of Medicine, 540 E. Canfield, Detroit, 48201

Sept. 22-23—Annual September Leadership Training Seminar, Michigan Branch, American Association of Medical Assistants, Holiday Inn-Crosstown, Kalamazoo, contact: Chairman Alice Covell, 1141 S. Rose, Kalamazoo, 49008

Sept. 26—Annual Muskegon County Trauma Symposium, Holiday Inn, Muskegon, contact: G. W. Annessa, MD, 1470 Peck St., Muskegon, 49441

Sept. 26-27—Family Practitioners' Conference on Mental Retardation. Towsley Center, University of Michigan, Ann Arbor, contact: ISMRRD, 103 S. First, Ann Arbor, 48101.

Oct. 4-5—Annual Harold C. Mack Symposium on the Physiology and Pathology of Human Reproduction, "Regulation of Fertility," at headquarters of Engineering Society Of Detroit, contact: Kamran S. Moghissi, MD, C. S. Mott Center, 275 E. Hancock, Detroit, 48201

Oct. 7-9—108th Annual Session, MSMS House of Delegates, Sheraton-Cadillac Hotel, Detroit, contact: Richard Campau, MSMS headquarters

Oct. 8-10—Annual meeting of the MSMS Auxiliary, Pontchartrain Hotel, Detroit, contact: Mrs. Dwight Dutcher, convention chairman, 711 S. Oxford Road, Grosse Pointe, 48236

Oct. 10-11—Annual MSMS Scientific Session, Sheraton-Cadillac Hotel, Detroit, contact: Helen Schulte, MSMS Headquarters

Nov. 20—Professional Activity Study and Medical Audit Program Institute, sponsored by Commission on Professional and Hospital Activities, at CPHA headquarters, Ann Arbor, AAFP elective hours, contact: CPHA, 1968 Green Road, Ann Arbor, 48105

Nov. 28-30—Physician postgraduate course, "Human Hypersensitivity Disorders: Clinical Aspects and Pathogenetic Mechanisms," sponsored by American College of Physicians, at U-M Medical Center, contact: ACP, 4200 Pine St., Philadelphia 19104

Jan. 15—Midwinter board meeting, MSMS Auxiliary, at MSMS headquarters, contact: Mrs. William J. Jones, president-elect, 15839 Crescent Drive, Allen Park, 48101

March 18-21—Physician postgraduate course, "Rheumatic Disease: Pathogenesis, Diagnosis and Treatment," sponsored by American College of Physicians, at U-M Medical Center, contact: ACP, 4200 Pine St., Philadelphia, 19104

March 27-28—Annual Michigan Conference on Maternal and Perinatal Health, the Pantlind Hotel, Grand Rapids, contact: Lloyd Kammeraad, MD, 1810 Wealthy St., SE, Grand Rapids, 49506, or Helen Schulte, MSMS Headquarters

April 24—Annual Legislative Day, MSMS Auxiliary, at Olds Plaza Hotel, Lansing, contact: Mrs. Robert J. Westerhoff, 2458 Maplewood, SE, Grand Rapids, 49506

April 24-25—Annual Spring Conference, MSMS Auxiliary, at Hospitality Inn, Lansing, contact: Mrs. William J. Jones, president-elect, 15839 Crescent Drive, Allen Park, 48101

MSU to offer group medical care to student families

An initial group of 500 married student families at Michigan State University will be provided with health and medical services under a prepaid group pilot program to be initiated in East Lansing in September.

Each family will be assigned to a small group of health professionals including a nurse, family physician, pediatrician, health care assistant and counselor. The program will operate on a fee for service basis and generally be self-supporting.

CPHA's second edition of H-ICDA now ready

The Commission on Professional and Hospital Activities of Ann Arbor announces that the second edition of its Hospital Adaptation of ICDA will be published in October and ready for use in 1974. Use of the first edition of the H-ICDA, published in 1968, has grown so that it is now estimated to be used for coding more patients in U.S. short-term general hospitals than any other classification.

Inquiries may be addressed to the CPHA, 1968 Green Road, Ann Arbor, 48105.

County scenes

Genesee doctors help patients understand billings

Genesee County physicians are helping improve MD-patient relationships with a simple tool that is also unique and effective.

They have prepared a message in effect saying "We don't know how Shield and government payments are being interpreted these days and you may have to pay this bill yourself."

The message is printed on a large white card, for display in the doctor's office, and on small yellow sheets, 100 to a pad, which may be enclosed with the doctor's bill to his patient.

"The messages serve to make the patients cognizant of their responsibilities," explains Norman Anderson, GCMS executive director. "They avoid misunderstandings. They really are a patient service.

Fifty-five GCMS members ordered the cards and yellow pads following a March meeting when Glenn E. Moore, GCMS president, first proposed distributing the messages. A total of 300 of the note pads and cards were ordered " and that means a lot of patients that will be notified," says Mr. Anderson.

The Genesee County society picked up the bill for the project, which Mr. Anderson suggests might be a good one for other county societies to copy. "These forthright, advance notices clear the air. The patients know at the outset what the situation is," he says.

The full text of the message is as follows: "The decision as to any payment for your medical care or hospitalization is determined at the sole discretion of your insurance carrier, whether it be an independent carrier, Blue Cross or Blue Shield, the Medicare section of the Federal Government or the Medicaid section of the Department of Social Services of the State of Michigan.

"Therefore, you are hereby advised and notified that you may be required to pay for the medical and hospital services provided if these agencies decide to disallow your claim for payment."

Ottawa County MDs aid seminary students with counseling course

Western Theological Seminary seniors of Holland and a few local pastors have completed a unique course on counseling people with medical problems, arranged in cooperation with the Ottawa County Medical Society.

Bernadine DeValois, MD, and Henry Ten Pas, MD, both of Holland, comprise the medical society's committee on medicine and religion which coordinated the effort with seminary faculty members.

Medical guests have included Arnold Dood, MD, Holland, and Jon Anderson, MD, Grand Haven, who dealt with "Life and Death." William Baum, MD, Holland, discussed medical ethics and counseling related to organ transplants. He teamed with Gary Robertson, MD, Grand Haven, to talk about population control.

Presenting medical ethics and counseling related to abortion, new genetic techniques and the wed and unwed mother were Doctors Robert Visscher of Grand Rapids and Vernon Boersma of Holland.

James Simpson, MD, of Grand Haven and J. D. Plekker, MD, Holland, made a presentation on drug abuse and alcohol counseling, while Peter DeVries, MD, Grand Haven, dealt with faith healing.

Doctor Zako new president of MAFP

Louis R. Zako, MD, Dearborn Heights, MSMS councilor and chairman of the MSMS Public Health Committee, is new president of the Michigan Academy of Family Physicians.

He was installed in ceremonies recently which also saw the election of Cecelia F. Hissong, MD, Dearborn, as MAFP president-elect. Doctor Zako succeeds Robert L. Vitu, MD, Saginaw.

New secretary of the MAFP is Michael Papo, MD, Chelsea, while new board members are Stanley L. Michael, MD, Traverse City; Harold F. Kendrick, MD, Pontiac; Duane Allen, MD, Jackson, and Edward Lockhart, MD, Detroit.

Charles R. Zimont, MD, of Constantine, previously vice speaker, was elevated to speaker of the house, and George Dean, MD, Southfield, was named vice speaker.

Small doses

Y. M. Alkar, MD, Birmingham,

is a new member of the clinical faculty of Michigan State University's Psychiatry Department. Doctor Alkar is director of the Birmingham General Psychiatric Clinic and a member of the Beaumont Hospital Staff, Royal Oak.

Philip M. Binns, MD, Grosse Pointe Woods,

is new acting chairman of the Wayne State University School of Medicine Department of Otolaryngology. He has been on the WSU faculty since 1964 and is also chief of the ear, nose and throat section at St. John Hospital, Detroit.

James Davis, MD, South Haven,

is new medical director of the Van Buren County Health Department. He has practiced in South Haven for 13 years and before that was an Air Force physician for 20 years. He is former chief of staff at South Haven Community Hospital, past president and secretary of the Van Buren Medical Society.

Jack S. DeTar, MD, Milan,

has retired after 42 years as a general practitioner in his community. He was honored with the naming of "Jack DeTar Day" in Milan July 22, which included a banquet and open house. Doctor DeTar was named Michigan Family Doctor of the Year in 1948 and Michigan's Foremost Family Physician in 1949. He is former president of the Michigan Health Council, former AMA speaker and past president of the American Academy of General Practitioners. In addition, he helped found the Milan Library, the Washtenaw County Health Department, the Milan Boys Club and the Milan Rotary Club.

David G. Dickinson, MD, Ann Arbor,

is new chief of clinical affairs at University Hospital, Ann Arbor. He assumed his three-year term on Aug. 1. Doctor Dickinson will serve as liaison with the hospital's active medical staff. Doctor Dickinson most recently was coordinator for professional services in Mott Children's Hospital, Ann Arbor.

Stuart Finch, MD, Ann Arbor,

former director of the Children's Psychiatric Hospital there, has moved to Tucson, Ariz., to take up private practice. Doctor Finch, who was professor of psychiatry at the U-M, also will serve as a consultant to the University of Arizona medical school's Department of Psychiatry. He is past president of the Michigan Society of Neurology and Psychiatry, and will be succeeded by Humberto Nagera, MD, director, U-M child analytic study program.

Henry Holt, MD, Rochester,

was one of two retiring physicians in Wayne State University Health Service to be honored at a reception on campus June 12. Doctor Holt joined the Wayne faculty in August, 1953, and served as team physician. He also was responsible for staff members' pre-employment physicals and surgery and fracture work for students.

Glenn W. House, MD, Greenville,

is the recipient of a gift from the Montcalm County Unit of the Michigan Heart Association, in honor of his 25 years of practice in Greenville. Doctor House organized the local heart chapter 15 years ago.

William H. Kelly, MD, Lansing,

is new acting medical superintendent, Ionia State Hospital. He succeeds A. A. Birzgalis, MD, who resigned July 7. Doctor Kelly has been clinical services director at the Ionia Hospital since 1970.

Judith W. Krupka, PhD, East Lansing,

is new director of admissions for the MSU College of Human Medicine. She has been associated with the MSU Counseling Center since 1969 and a member of the College of Human Medicine admissions committee since 1971.

Frederick C. Sabin, MD, Marquette,

is a new member of the Alma College Board of Trustees. He was one of four new trustees elected at the annual spring meeting. Doctor Sabin also serves as chairman of the Northern Michigan University Board of Control.

(Continued on page 638)

A.C. Stander, MD, Saginaw,

is the Michigan Academy of Family Physicians' "Family Physician of the Year." He was named at the academy's recent annual meeting in Traverse City. Doctor Stander is a former MSMS Councilor and past president of the Saginaw County Medical Society. He began family practice in Saginaw in 1937.

Garfield Tourney, MD, Detroit,

is now chairman of the WSU School of Medicine's Department of Psychiatry. He succeeds Jacques S. Gottlieb, MD, who has held the post for seven years. Doctor Gottlieb continues as director of Lafayette Clinic and professor of psychiatry at WSU.

Robert Trimby, MD, Lansing,

pediatrician for 28 years, is leaving his private practice to become a medical services director in the state vocational rehabilitation division.

George Westcott, MD, Ypsilanti,

has closed his general surgery practice of nearly 25 years and is now serving as a medical missionary in the Republic of Zaire, formerly the Congo. He serves with the Africa Inland Mission at the Nyankunde Medical Center, a 250-bed hospital with more than 1,000 out-patients each day. Doctor Westcott, who is 70, previously spent 14 years as a medical missionary in Zaire.

Henry J. Winkler, MD, L'Anse,

is the 1973 recipient of Michigan Technological University's Distinguished Service Award. He is honored as "a good friend of Michigan Tech, an outstanding citizen of the Copper Country and a dedicated physician who has shown the deepest concern for his fellow man throughout his life."

Five Detroit-area physicians

are new public voting members of the Greater Detroit Area Hospital Council, Inc. They are Waldo Cain, MD; Sidney E. Chapin, MD; Robert D. Coye, MD; Charles N. Inniss, MD, and Marjorie Peebles Meyers, MD. Doctor Inniss and Doctor Peebles Meyers also were named to the council executive committee and the board of directors.

ALSO AVAILABLE FOR THE TREATMENT OF

impotence

due to androgenic deficiency in the American male.

Android® 5 MUQETS BUCCAL Tabs
Methyltestosterone N.F. - 5 mg.

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Methyltestosterone N.F. - 25 mg.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en 3-one.

ACTIONS. Methyltestosterone is an oil soluble androgenic hormone.

INDICATIONS: In the male· 1 Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are seconlary to androgen deficiency. 3 Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism.

Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

PRECAUTIONS: Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

CONTRAINDICATIONS: Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

WARNINGS: If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastic breast carcinoma. If this occurs, the drug should be discontinued.

ADVERSE REACTIONS: Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastic breast carcinoma This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

DOSAGE AND ADMINISTRATION: Dosage must be stricly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as an average daily dosage guide.

INDICATION	Average Daily Dosage Tablets
In the male:	
Eunuchoidism and eunuchism	10 to 40 mg.
Male climacteric symptoms and impotence due to androgen deficiency	10 to 40 mg.
Postpuberal cryptorchism	30 mg.

HOW SUPPLIED: 5, 10, 25 mg. In bottles of 60, 250.

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"Antiacid" action—Pro-Banthīne® (propantheline bromide) reduces gastric secretory volume and resting total and free acid.

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High-level anticholinergic activity is maintained all day and all night in most patients with only two tablets every eight hours.

"Analgesic" action—Pro-Banthīne helps to control the acid-spasm-pain complex.

A "diagnostic tool"—Pro-Banthīne may be used parenterally to immobilize the duodenum for more revealing roentgenographic appraisal through hypotonic duodenography.

Pro-Banthīne is considered adjunctive in total peptic ulcer therapy that may include diet, conventional antacids, bed rest, and other supportive measures.

Vigorous anticholinergic action — Pro-Banthīne® Vials, 30 mg., are for intramuscular or intravenous use when prompt and vigorous anticholinergic action is required.

Mild anticholinergic action—Pro-Banthīne® Half Strength, 7.5-mg. tablets, for more exact adjustment of maintenance dosage in mild to moderate gastrointestinal disorders.

Indications: Pro-Banthīne is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution.

Fever and possibly heat stroke may occur due to anhidrosis.

In theory a curare-like action may occur, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthīne.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

Pro-Banthīne P.A.—Each tablet of Pro-Banthīne P.A. (propantheline bromide) contains 30 mg. of the drug in the form of sustained-release or timed-release beads; on ingestion about half of the drug is released within an hour and the remainder continuously as earlier increments are metabolized. Thus the result is even, high-level anticholinergic activity maintained all day and all night in most patients with only two tablets daily. Some patients may require one tablet every eight hours.

The contraindications and precautions applicable to Pro-Banthīne 15 mg. should be observed.

How Supplied: Pro-Banthīne is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

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ABBOTT

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(ETHCHLORVYNOL)

Brief Summary

Indications—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

Contraindications—Drug hypersensitivity and porphyria.

Warnings—Not recommended during the first and second trimester of pregnancy. Caution patients of possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

Precautions—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitryptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

Adverse Reactions—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 304431

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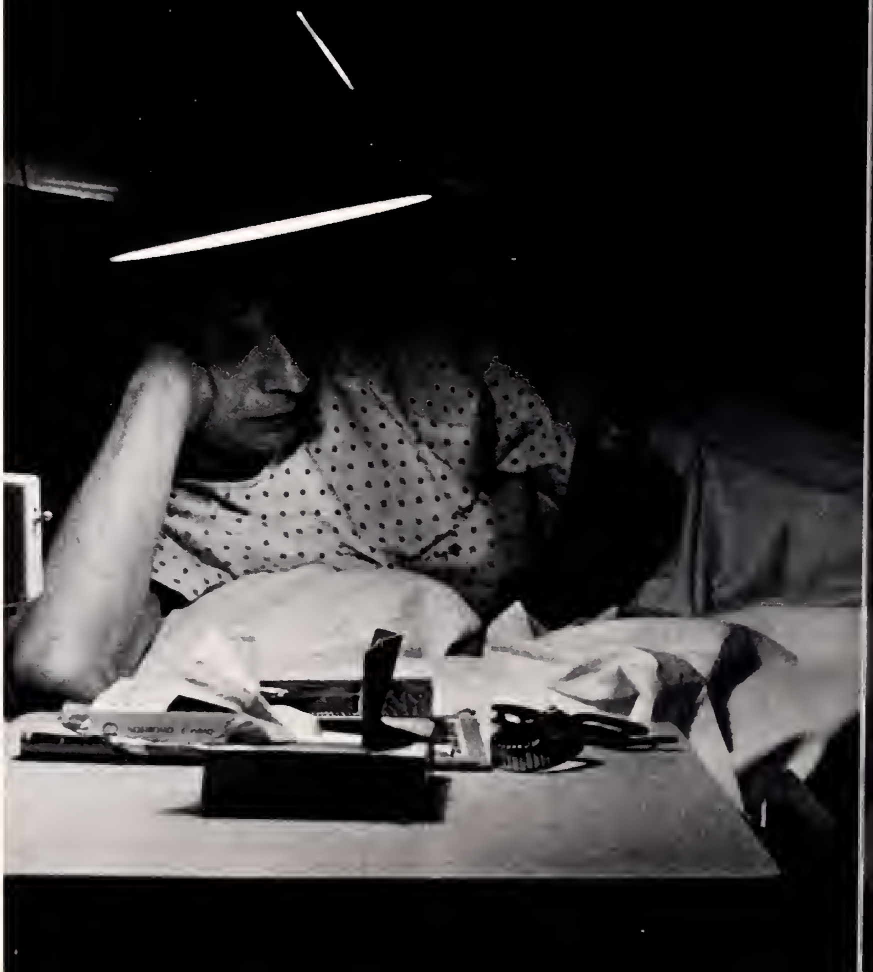

Delegates and alternates for 1973 MSMS House of Delegates meeting

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Vice Speaker:

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Warren S. Wille, MD, 5325 Brown Lake Road, Jackson 49203

Section on Public Health and Preventive Medicine
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Ophelia V. Baker, MD, 1600 N. Michigan, Saginaw 48602

Section on Radiology
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Gordon L. Bartek, MD, 833 Lake Dr., S.E., Grand Rapids 49506

Section on Surgery
Michael N. Zelenock, MD, 15830 Fort St., Southgate 48195
Robert D. Allaben, MD, 18255 W. McNichols Rd., Detroit 48219

Section on Thoracic Surgery (The Michigan Society of Thoracic Surgeons)
To Be Named

Section on Urology (Detroit Branch American Urological Society)
David Siegel, MD, 2909 E. Grand River, Lansing 48912
David B. Johnson, MD, 2909 E. Grand River, Lansing 48912

Plans proceeding for new MSMS section

It is anticipated that following the 1973 MSMS House of Delegates Annual Session early in October MSMS will have a new Section on Clinical Pharmacology and Therapeutics.

The organizational meeting of this section has been arranged for 2 to 3:15 p.m. Wednesday, Oct. 10, immediately following the House of Delegates meeting. The acting chairman is Chris J. D. Zarafonetis, MD, who may be reached for further information at the Simpson Memorial Institute, Ann Arbor, 48106.

Michigan authors

Articles

Jaime V. Aragones, MD, Rochester, "The treatment of Blepharitis, a controlled double blind study of combination therapy," *Annals of Ophthalmology,* January, 1973.

William Martel, MD, Ann Arbor, "Carcinoma following gastroenterostomy," page 52, *Journal of the American Medical Association,* July 2, 1973.

Ronald L. Krome, MD; Robert F. Wilson, MD, and Spencer R. Schron, Detroit, "Survey preludes regional planning: Survey Data on Detroit's services should facilitate development of a regional plan to utilize existing facilities more efficiently," page 135, *Hospitals,* May 16, 1973.

Manuel Sklar, MD, FACG, and Vladimir Uhri, MD, Detroit, "Cholestyramine: factors limiting its antidiarrheal effect in patients resected for regional enteritis," page 397, *American Journal of Gastroenterology,* May, 1973.

Pritpal S. Puri, MD, Detroit, "Heart failure and shock in acute myocardial infarction; concepts, components and figurations," page 108, *Journal of the American College of Emergency Physicians,* March/April, 1973.

Fred W. Whitehouse, MD, Detroit, "Infections that Hospitalize the Diabetic," page 97, *Geriatrics,* July, 1973.

Jay S. Finch, MD, Plymouth, "Pharmacology for the Respiratory Therapist: Anesthetic Agents," page 27, *The Michigan Airway,* June, 1973.

Books

"Jail House Blues," by Bruce Danto, MD, Detroit, director, Detroit Suicide Prevention and Drug Information Center, and assistant professor, Wayne State University School of Medicine Department of Psychiatry, a discussion of the suicidal inmate as a human being, and of the prison conditions which contributed to his suicide, published by Epic Publications, Inc., Orchard Lake, $8.95 per copy.

Dear Doctor:

This month's "Bio-Science Reports," on the page opposite, is another service of Bio-Science Laboratories.

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Director

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Bio-Science Reports

Plasma Testosterone as a Diagnostic Aid in Adult Women

Although controversy still persists as to the clinical value of plasma versus urinary androgen assays, the consensus is that free hormone levels in plasma more closely reflect the physiological effects at the target tissues. As with other hormones, the testosterone level in plasma reflects a result of alterations of both the production rate and the metabolic clearance rate.

The advent of new assay technics has enabled the laboratory to measure with accuracy and specificity the low levels of testosterone found in women and prepubertal children. The competitive protein-binding method we formerly used, published by the Research Staff at Bio-Science(1), was recently superseded by a new radioimmunoassay procedure(2) with significantly greater sensitivity.

The range of plasma testosterone in normal adult females extends from 30 to 95 nanograms/100 ml. (1 ng = .001 microgram). Although there is no evidence of a diurnal variation in women, plasma levels are higher during the ovulatory and luteal phases of the cycle. During pregnancy the concentration increases significantly but has no relationship to the sex of the fetus.

Polycystic Ovary (Stein-Leventhal Syndrome):
Levels were found to be above normal (100-300 ng/100 ml.) in one study(3). ACTH or glucocorticoid administration resulted in a drop in testosterone levels(4).

Idiopathic Hirsutism:
Plasma testosterone levels in these cases range from 30 to 300 ng/100 ml. Variable effects on the testosterone levels have been reported following ACTH, HCG and FSH administration. Synthetic glucocorticoid or estrogen-progesterone combinations reduce elevated levels to the normal range(3, 5).

Virilizing Tumors:
Arrhenoblastomas, dermoids, malignant teratomas and possibly other tumors may secrete testosterone.

Specimen Required:
2 ml. serum or plasma. Specimens are stable without refrigeration or preservative for 7 days.

References:
1. Demetriou, J. A. and Austin, F. G., Clin. Chem., *16*:111, 1970
2. Thorneycroft, I. H. and Stone, S. C., Contraception, *5*:129, 1972
3. Bardin, C. W. and Mohoudeau, J. A., Ann. Clin. Res., *2*:251, 1970
4. Horton, R. and Neisler, J., J. Clin. Endocr. and Metab., *28*:479, 1968
5. Casey, J. H. and Nabarro, J. D. N , J. Clin. Endocr. and Metab., *27*:1431, 1967

25 YEARS

Main Lab: 7600 Tyrone Ave.,
Van Nuys, California 91405

Philadelphia Branch:
116 So. Eighteenth St.,
Philadelphia, Pa. 19103

Bio-Science Laboratories
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(write in name of test)

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Address ______________________

City ____________ State ____________ Zip ____________

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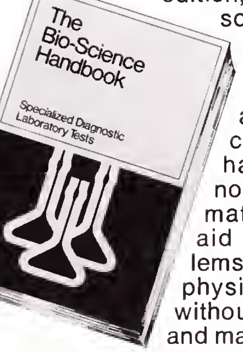

This 200-page book, now in its tenth edition, is a uniquely informative source to keep you up-to-date on the newer laboratory tests, such as testosterone and other androgens, available to clinicians. You will find it a handy reference guide for normal values and quick summations on tests which can aid in your diagnostic problems. Copies are available to physicians and lab personnel without obligation. Simply fill out and mail this coupon.

Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

A. B. Albarracin, MD, 3360 Charlevoix, Detroit 48207
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Nandalal Bagchi, MD, Hutzel Hospital, Detroit 48201
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Stuart L. Bloom, MD, 24860 Towne Rd. #410, Southfield 48075
Brooks F. Bock, MD, 1326 St. Antoine, Detroit 48226
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David Yul Ha Cho, MD, 30910 Longview, Warren 48093
Richard E. Dean, MD, 220 Cherry St., S.E. Grand Rapids 49503
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(Continued on page 663)

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Opinion & Dialogue

"Prescription drugs – who should determine the maker?"

Dispenser of Medicine

Clifton J. Latiolais
President
American Pharmaceutical Association

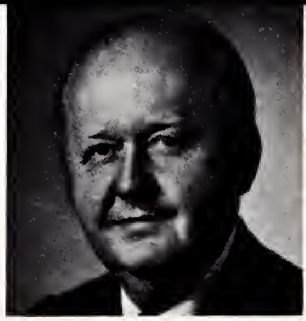
"Too many doctors are indiffe
ent to the economic consequences
their decisions." So stated a recent
issue of *Medical News Report* (De-
cember 4, 1972), an independent
weekly newsletter published by forr
AMA Chief Executive F. J. L. Blasin
game, M.D.

Doctor, are you indifferent...?

In discussing an anticipated i
crease in Blue Shield rates, Dr. Bla
ingame's newsletter had this to say

"In general, it can be said, MD
have given the impression they are
not particularly concerned with the
increase in cost of health care to th
patients...

"True, an MD's training is pri-
marily scientific, but in the real wo
of practice, all of his scientific deci
sions have a price tag, or an econo
impact. The economics of health c
beckon the practitioner's attention
Concern for economics of medicin



Maker of Medicine

C. Joseph Stetler
President
Pharmaceutical Manufacturers Association

When the pharmacist recom-
mends that a drug product other th
the one ordered be dispensed, the
prescriber invariably permits the
change when he feels the best inte
ests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is nec
sary for the prescriber to know tha
the change is being contemplated,
and to be in a position to consent o
demur. Without that opportunity, t
unilateral decision of the pharmac
made in the absence of clinical kno
edge of the patient, could expose h
to needless risks, and in addition,
jeopardize the relationship betwee
the professions of Pharmacy and
Medicine. In my view, there is noth
in the pro-substitution argument th
offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim
that the primary justification for
changing the rules is the desire to
better utilize pharmacists' knowle
about drugs. Yet the pharmacist's
task to keep current on the entire
field of drug therapy, to some degr
puts him at a disadvantage. Most
often, a practicing physician will n
expert knowledge of no more than

Advertisement

should be an obligation of medical practice...

"Medical societies ought to conduct continuing campaigns to point out the substantial savings that could be realized thru deductible insurance and protection for catastrophic illness. At the very least, they should, in he patients' interest, question the actics of any insurance organization hat raises health care costs by forcing policyholders to buy insurance hey may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of heir decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's nonsense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed o their patients for support in the ight against government interference with the private practice of medicine. And the public in the past has responded. It's time the American Medical Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

Cost of Drugs

Insurance rates and hospital charges are only two factors in health care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists *are concerned*. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

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or 30 drugs that he selects to treat the majority of conditions encountered in his practice. Moreover, the physician's choice of a specific brand is based on his knowledge of the patient's medical history and current condition, and his experiences with the particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party transaction between the pharmacist and the patient, and that a substituting pharmacist may avoid even a technical breach of contract by simply notifying the patient that he is making the substitution. I would judge that few courts would be sympathetic toward a pharmacist who substituted without physician approval and who undertook a legal defense that seeks to make the patient responsible for the pharmacist's actions.

Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and particularly the consumer activist, that reduced prescription prices could follow legalization of substitution. We have seen absolutely no evidence to justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advocates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

Pharmaceutical
Manufacturers Association
1155 Fifteenth Street, N.W.
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You've got 4-wheel self-adjusting disc brakes, and independent wheel suspension. Not to mention a 5-speed gearbox, and electronic fuel injection. In other words, you've got confidence.

But you've also got it cozy.

A weatherproof fiberglass roof, removable for when it's sunny. And a flow-through ventilation system for when it's not.

Bucket seats that hug you like the car hugs the road. That don't just slide back and forth, but tilt up and down for whatever angle is your angle.

And all that legroom up front where the engine isn't.

And all that luggage room too, with trunks front and back.

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Here is list of U - M postgrad courses for 1973 - 74

Courses of General Interest to Physicians

COPD: A Program for Therapy and Rehabilitation—Nov. 8, 1973
Respiratory Therapy Conference—Jan. 11-12, 1974
Emergency Medicine—Feb. 26-Mar. 1, 1974
Electrocardiographic Diagnosis — Mar. 26-28, 1974
Northern Michigan Summer Course—June 24-28, 1974

For Family Practitioners (with the Michigan Academy of Family Physicians)

Blood Pressure and Blood Gases: Current Concepts in Clinical Practice—Nov. 23-24, 1973
Coronary Heart Disease—Dec. 5, 1973
Family Practice Review— Jan. 21-25, 1974
Therapeutics—May 8-9, 1974
Pulmonary Disease Workshop—June 13-14, 1974

For Surgeons

Plastic Surgery for General Surgeons— Nov. 1-3, 1973
Advanced Burn Care (General Surgeons: Plastic Surgeons)—Nov. 9-10, 1973
Vascular Surgery (General Surgeons)— Mar. 14-15, 1974
Surgical Anatomical Review (Surgical Residents)—Apr. 8-May 3, 1974
Advances in Clinical Neuroscience (Neurosurgeons)—June 3-5, 1974

For Internists

Advances in Cardiology for Internists—Oct. 2-4, 1973
Advances in Internal Medicine—May 20-23, 1974

Other Medical Specialty Courses

Blood Coagulation Techniques (Pathologists)—Sept. 11-13, 1973
Anesthesiology Conference (Anesthesiologists)—Nov. 23-24, 1973
Role of the Nervous System in Hypertension (Academic Clinicians, Internists and Basic Scientists)—Feb. 4-6, 1974
Advances in Pediatrics (Pediatricians)—Mar. 7-8, 1974
Feto-Maternal Monitoring (Obstetricians and Gynecologists)
Basic:—Mar. 11, 1974
Advanced:—Mar. 12, 1974
Ob-Gyn Conference (Obstetricians and Gynecologists)— Apr. 1-3, 1974
Neuroendocrine Integration: Basic and Applied Aspects—Apr. 16-18, 1974
Glaucoma Conference (Ophthalmologists)—May 2-4, 1974
Symposium on the Biology of Cancer (Academic Clinicians and Basic Scientists)—May 15-16, 1974

Additional courses will be added during the year. For further information or to receive copies of course announcements contact: Robert K. Richards, Director, Office of Intramural Education, Towsley Center, University of Michigan Medical Center, Ann Arbor, 48104.

U-M opens birth defect center

Michigan's first birth defect diagnostic center is now open in the Holden Perinatal Research Laboratories of University Hospital, Ann Arbor. In addition to diagnosis of apparent abnormalties in children, the center will provide therapy for conditions which can be treated, preventive services in the form of genetic counseling, and tests for abnormalties in parents or the fetus as early as the 13th week.

Recommendations[†] on Combination Live Virus Vaccines

American Academy of Pediatrics

Committee on Infectious Diseases

In the September 15, 1971 *AAP Newsletter* sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."

United States Public Health Service

Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidity and Mortality Weekly Report*, the Advisory Committee on Immunization Practices of the United States Public Health Service presented recommendations on the use of combination live virus vaccines. The committee stated that:

- "Data indicate that antibody response to each component of these combination vaccines is comparable with antibody response to the individual vaccines given separately.
- "There is no evidence that adverse reactions to the combined products occur more frequently or are more severe than known reactions to the individual vaccines (see pertinent ACIP recommendations).
- "The obvious convenience of giving already selected antigens in combined form should encourage consideration of using these products when appropriate."

[†] For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.

M-M-R*

(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials

M-M-R, given in a single injection, fits easily into your routine immunization program for well babies.

Given at age 12 months, M-M-R provides for vaccination early in life against measles, mumps, and rubella.

MSD suggested immunization schedule for well babies

Age	Vaccine(s)
2 months	DPT (diphtheria-pertussis-tetanus) Oral poliomyelitis vaccine (triple)
3 months	DPT[1]
4 months	DPT Oral poliomyelitis vaccine (triple)
6 months	Oral poliomyelitis vaccine (triple)
12 MONTHS	**M-M-R (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE, MSD)**

[1] This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.

Since vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and the vaccine should not be given during the same office visit.

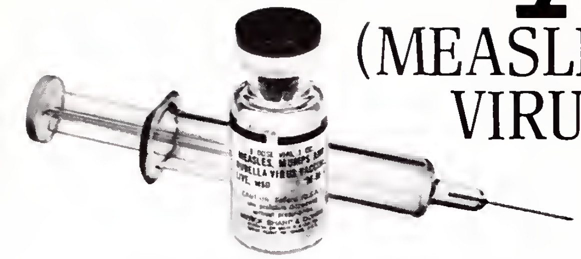
*Trademark of Merck & Co., Inc.

For a brief summary of prescribing information, please see following page.

M-M-R

(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials



No untoward reactions peculiar to the combination vaccine (M-M-R) have been reported.

Moderate fever (101–102.9 F) occurs occasionally. High fever (over 103 F) occurs less commonly. On rare occasions, children who develop fever may exhibit febrile convulsions. Rash (usually minimal and without generalized distribution) may occur infrequently.

Since clinical experience with measles, mumps, and rubella virus vaccines given individually indicates that very rarely encephalitis and other nervous system reactions have occurred, such reactions may also occur with M-M-R. A cause and effect relationship, however, has not been established.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Must not be given to women who are pregnant or who might become pregnant within three months following vaccination.

Contraindications: Pregnancy or possibility of pregnancy within three months following vaccination; infants less than one year old; sensitivity to chicken or duck, chicken or duck eggs or feathers, or neomycin; any febrile respiratory illness or other active febrile infection; active untreated tuberculosis; therapy with ACTH, corticosteroids, irradiation, alkylating agents, or antimetabolites; blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems; gamma globulin deficiency, i.e., agammaglobulinemia, hypogammaglobulinemia, and dysgammaglobulinemia.

Precautions: Administer subcutaneously; do not give intravenously. Epinephrine should be available for immediate use should an anaphylactoid reaction occur. Should not be given less than one month before or after immunization with other *live* virus vaccines; vaccination should be deferred for at least six weeks following blood transfusions or administration of more than 0.02 cc immune serum globulin (human) per pound of body weight, or human plasma.

Due caution should be employed in children with a history of febrile convulsions, cerebral injury, or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur after vaccination.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Attenuated live virus measles and mumps vaccines, given separately, may temporarily depress tuberculin skin sensitivity; therefore, if a tuberculin test is to be done, it should be scheduled before vaccination, to avoid the possibility of a false negative response.

Before reconstitution, refrigerate vaccine at 2–8 C (35.6–46.4 F) and *protect from light*. Use only diluent supplied to reconstitute vaccine. If not used immediately, return reconstituted vaccine to refrigerator at 2–8 C (35.6–46.4 F), and discard after eight hours.

Adverse Reactions: Fever, rash; mild local reactions such as erythema, induration, tenderness, regional lymphadenopathy; parotitis; thrombocytopenia and purpura; allergic reactions such as urticaria; arthritis, arthralgia, and polyneuritis.

Occasionally, moderate fever (101–102.9 F); less commonly, high fever (above 103 F); rarely, febrile convulsions.

Encephalitis and other nervous system reactions that have occurred very rarely with the individual vaccines may also occur with the combined vaccine.

Transient arthritis, arthralgia, and polyneuritis are features of natural rubella and vary in frequency and severity with age and sex, being greatest in adult females and least in prepubertal children. Such reactions have been reported with live attenuated rubella virus vaccines. Symptoms relating to joints (pain, swelling, stiffness, etc.) and to peripheral nerves (pain, numbness, tingling, etc.) occurring within approximately two months after immunization should be considered as possibly vaccine related. Symptoms have generally been mild and of no more than three days' duration. The incidence in prepubertal children would appear to be less than 1% for reactions that would interfere with normal activity or necessitate medical attention.

How Supplied: Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 $TCID_{50}$ (tissue culture infectious doses) of measles virus vaccine, live, attenuated, 5,000 $TCID_{50}$ of mumps virus vaccine, live, and 1,000 $TCID_{50}$ of rubella virus vaccine, live, expressed in terms of the assigned titer of the NIH Reference Measles, Mumps, and Rubella Viruses, and approximately 25 mcg neomycin, with a disposable syringe containing diluent and fitted with a 25-gauge, ⅝″ needle. Also in boxes of 10 single-dose vials nested in a pop-out tray with a separate box of 10 diluent-containing syringes.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

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In memoriam

Wyman C. C. Cole, MD
Walnut Creek, Calif.

Former chief of pediatrics at Hutzel Hospital, Wyman C. C. Cole Sr., MD, died June 30 at the age of 80. He was retired and living in California.

Doctor Cole was a past president of the Wayne County Medical Society and for 11 years served as secretary of the pediatrics section of the AMA. He also had been a member of the MSMS Council and a Wayne County delegate to the MSMS House.

Doctor Cole had been secretary for 11 years of the pediatric section of the AMA and was the recipient of the Grulee Gold Medal of the American Academy of Pediatrics for his service to that society.

Doctor Cole was graduated from the University of Minnesota Medical School and was affiliated with Hutzel, Harper and Children's hospitals in Detroit.

Heman E. Grant, MD
Babson Park, Fla.

Retired eye, ear, nose and throat physician Heman Emory Grant, MD, died June at the age of 94. He was residing in Florida.

Doctor Grant was a graduate of the University of Michigan Medical School and practiced in Albion and Detroit, where he was affiliated with Grace Hospital. He was in practice for 40 years and belonged to the Detroit Otolaryngological Society.

Vilda S. Laurin, MD
Muskegon

Long-time Muskegon physician Vilda S. Laurin, MD, died July 2 at the age of 85. He had practiced 60 years.

Doctor Laurin was a native of Canada and was graduated from the University of Illinois School of Medicine. He served on the Muskegon Board of Health from 1935 to 1946 and on the board of the Muskegon County Society for Crippled Children. He was a fellow of the American College of Surgeons.

Doctor Laurin set up a foundation to give a yearly $1,000 scholarship to a local law student and established several programs to aid local nursing students.

Doctor Laurin discontinued his surgical practice in 1945 but remained active in medical service to industry.

Sol M. Lewis, MD
Ferndale

Sol M. Lewis, MD, Ferndale generalist for over 50 years, died July 24 at the age of 81.

Doctor Lewis was deputy medical examiner for Oakland County for 26 years, and was affiliated with Sinai and Ardmore hospitals in Detroit. He was a graduate of the Wayne State University School of Medicine which in 1968 honored him for his 50 years of medical practice.

Doctor Lewis played bassoon with the Detroit Symphony Orchestra for many years and was an electrical engineer and inventor, having built computers and clocks. He also designed and made furniture.

Colin C. McCormick, MD
Detroit

Retired Detroit surgeon Colin C. McCormick, MD, died June 28 at the age of 75. Doctor McCormick had been chief of staff at Delray Hospital, Detroit for 30 years until his retirement in 1960.

He was a graduate of the University of Michigan Medical School in 1922, exactly 50 years after his father was graduated from the same school. He also was affiliated with Oakwood Hospital, Dearborn, and was a member of the International College of Surgeons.

Donald A. Parker, MD
Adrian

Donald A. Parker, MD, Adrian radiologist, died July 14 at the age of 62. He had been affiliated with Bixby Hospital in Adrian and Herrick Memorial Hospital in Tecumseh.

Doctor Parker was a member of the Detroit Roentgen Ray Society, the Radiological Society of North America and the American College of Radiology.

(Continued on page 663)

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IN MEMORIAM/Continued

Desmond K. Rush, MD
Bloomfield Township

Desmond Keiran Rush, MD, 45, chief of the radiology department of St. Mary Hospital, Livonia, died in a New York plane crash on July 13.

Doctor Rush was a native of Saskatchewan and was graduated from the University of Ottawa medical school.

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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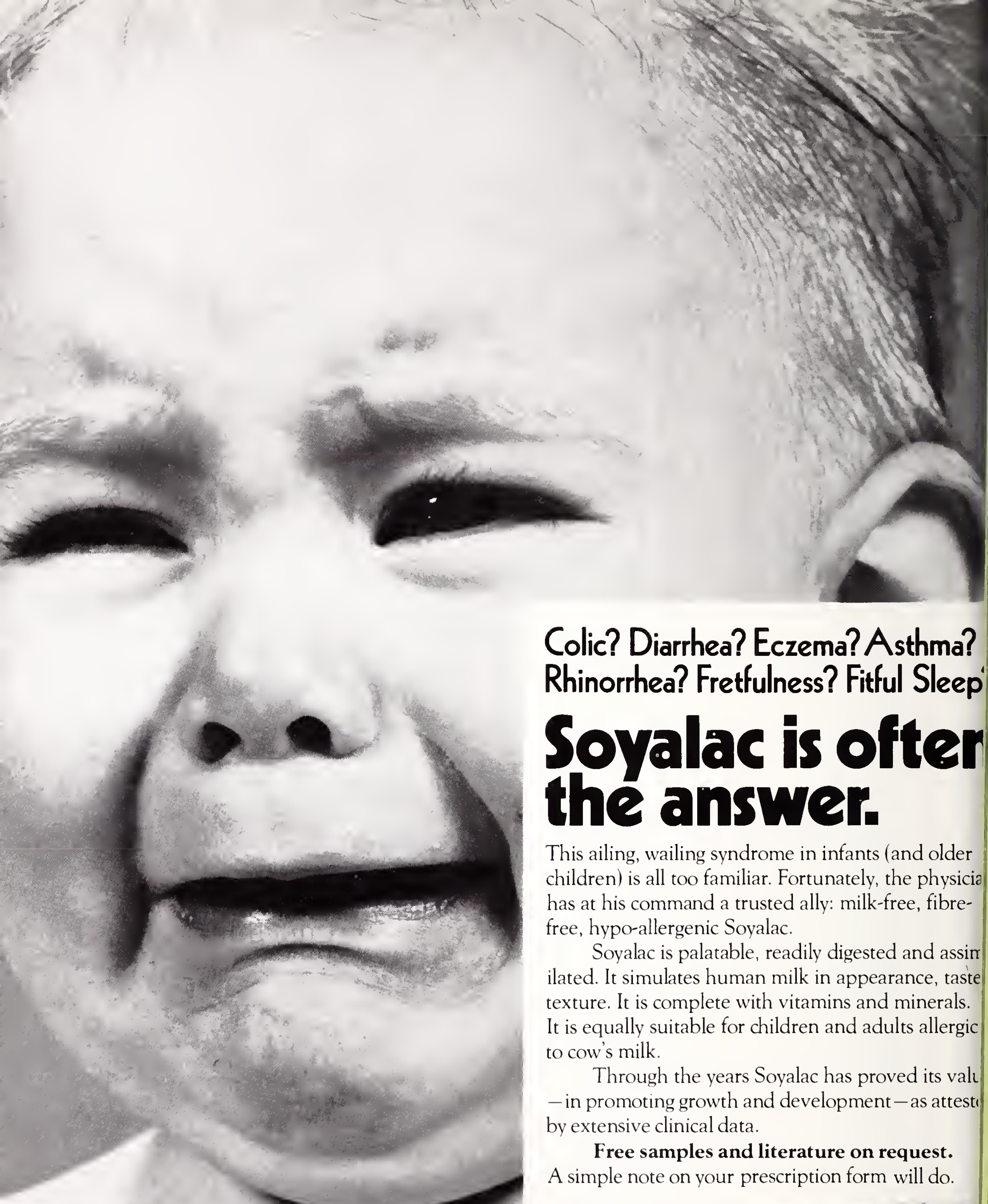

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Here are HMO questions and answers

Questions and answers

Here's a summary of legislative proposals, Michigan activity in organization of HMOs

By Herbert Mehler
MSMS Staff

What is an HMO?

Without actual laws and regulations, any definition of a health maintenance organization must be tentative. However, Congressional versions in previous and current proposals contain definitions which vary only in details and, consequently, a general outline of an HMO definition may be advanced.

The United States Department of Health, Education and Welfare describes an HMO as follows:

An HMO should have the basic capacity to provide such services (emergency, inpatient, physician, ambulatory care and outpatient preventive medical services) directly or arrange for such services to be obtained from other providers. As a minimum, an HMO would be required to provide directly, or have effective arrangements for the provision of and payment for, physicians' care, hospital care, emergency care and preventive services.

Anatomy of an HMO

1. What are the principal elements of an HMO?
2. What is MSMS (and AMA) position on HMOs?
3. Are there any HMOs in Michigan now?
4. What plans are the medical schools making for HMOs?
5. Does MSMS favor HR-51 or S-14 (dealing with HMOs) in Congress?
6. Is SB-182 still alive in Michigan legislature?
7. What are the advantages claimed by HMO promoters? What are the disadvantages?

These questions and others are being asked by many doctors in Michigan and by legislators, planners and others.

This article answers the questions and provides up to date information for MSMS members about Health Maintenance Organizations.

The American Medical Association states:

While there are popular concepts concerning the health maintenance organizations there is no clear definition outside of proposed legislation and there is no common definition in the various bills. The generally recognized elements of a definition of an "HMO" would be an organization or agency, under grant from or contract with the Secretary (HEW), which agrees to meet prescribed requirements and assumes responsibility for providing both institutional and professional health services to a specified population on the basis of a fixed prepaid dollar amount per person. The "HMO" should not be equated with existing organizations.

Thus, based on the HEW and AMA definitions, an HMO might be described as:

—An organized system of health care which accepts the responsibility to provide or otherwise assure the delivery of

—an agreed upon set of comprehensive health maintenance and treatment services for

—a voluntarily enrolled group of persons in a geographic area and

—is reimbursed through a prenegotiated and fixed periodic payment made by or on behalf of each person or family unit enrolled in the plan.

What are AMA and MSMS positions on HMOs?

The American Medical Association testified before the U.S. Senate Finance Committee in September, 1970, that:

"We support a pluralistic approach to the delivery of medical services. However, before any HMO program is initiated nationwide through legislation and held out as a realistic benefit available to all Medicare beneficiaries, we believe that cost and utilization data should first be developed with controlled demonstrations testing the capability of such a program to accomplish its purpose. There are questions regarding in-fact cost savings, as well as the quality of health care which may be provided when there are economic incentives to providers to reduce utilization. We would wish to assure that Medicare patients uniformly receive the best quality care. We recommend that organizations delivering health care should be under control and guidance of medical personnel."

In June, 1971, in the AMA House of Delegates resolved:

"That the HMO concept is still experimental and unproven as a nationally applicable solution to problems of health care delivery—and that the AMA continue to study and evaluate HMOs and to keep the profession advised."

The Michigan State Medical Society has stated that prepaid contract medical care (the HMO) has a role in the pluralistic system. In 1970, the MSMS House of Delegates Resolution 15 stated:

"MSMS recognized that there are currently many acceptable methods of practicing medicine."

On May 2, 1972, the MSMS Council stated:

"Michigan State Medical Society believes in a multiplicity of approaches to the delivery of health care. It believes prepaid group practice may be one of those approaches and further that government sponsored prepaid group practice may also be useful."

On Aug. 23, 1972, the MSMS Council responded to guidelines by the Department of Social Services by citing specific difficulties that HMOs could experience.

The MSMS Committee on Legal Affairs also has commented on projected legislation being considered by the Governor's Office of Health and Medical Affairs.

What is status of HMO legislation in Congress?

There are a number of bills pending in Congress. Following are brief resumes:

HR-7974 (clean bill approved in lieu of HR-51) (Rogers, D-Fla.; Roy, D-Kans.). Authorizes 280.7 million dollars over a five-year period to encourage expansion and development of 100 HMOs on an experimental basis. Money may be spent for feasibility studies. . . planning, initial development costs. . . loans for initial costs . . . evalutation of program effectiveness. Coverage: open to all in test areas. Employers required to offer option of HMO coverage to employees, but cost to firm cannot exceed outlays under company sponsored health insurance programs. Services offered: comprehensive. . . including physicians' services, inpatient, outpatient, hospital and extended care, diagnostic and rehabilitation, preventive health.

S-14 (Kennedy, D-Mass.; Williams, D-N.J.; others). Authorizes 1.5 billion dollars over three years to encourage expansion, development of HMOs on permanent basis. Money may be spent for feasibility studies. . . planning, initial development costs. . . construction grants and loans. . . grants and loans for operating costs. Also establishes: Quality Health Care Commission and Federal Malpractice Re-insurance Program. Coverage: everyone. Services offered: All services in HR-7974 but even more comprehensive in scope.

HR-4871 (Staggers, D-W.Va.; Devine, R-Ohio); *S-927* (Javits, R-N.Y.; Schweiker, R-Pa.) for the administration. Authorizes an unspecified sum (1974 budget provides 60 million dollars) to encourage expansion and development of HMOs on an experimental basis. Funds would be available for payment of planning costs. . . initial operating costs and medically-underserved areas. Coverage: not specified. Services offered: Physician, hospitals, health maintenance. The adminstration's bill is a far more limited demonstration proposal than HR-7974.

In March, 1973, the MSMS Committee on Governmental Medical Care Programs recommended that The Council adopt the following statement:

> "That MSMS urge the AMA to express a preference for HR-51 over S-14 as Federal HMO legislation." (HR-7974 replaced HR-51 as a clean bill.)

The Council re-referred the recommendation to the committee pending AMA action on an administration bill.

As of July 7, 1973, the U.S. House of Representatives had completed hearings on S-14. The Senate passed the bill on May 15, 1973. Senate passage of S-14 was accomplished only after the Javits-Kennedy proposal to cut the authorization of 805 million dollars for fiscal years 1974-76 was adopted. A requirement for health service organizations (HSOs) in rural areas was eliminated. The House Commerce Committee will likely approve an experimental, pilot-testing approach.

The House passed HR 7974 on Sept. 12 by a vote of 369-40. Conferees are expected to be selected soon from Senate and House Health Subcommittees. The bill has President Nixon's support as a "fiscally responsible demonstration effort." Essentially, the bill lowers costs to 240 million dollars, authorizes feasibility studies and planning and deletes construction loan guarantees, preemption of state laws prohibiting or hindering development and other specific items.

Public Law 92-603 amended numerous provisions in Medicare-Medicaid and, of equal importance, officially sanctioned health maintenance organizations. Now HMOs can provide for two types of contracts with HEW. One is a risk-sharing contract that calls for the HMO to provide all services to which a Medicaid patient is entitled for one year. If these services are delivered at a lower cost than fee-for-service in that geographic area, the HMO and the Medicare Trust Fund share the savings; if the cost is higher than to non-HMO beneficiaries, the "loss" is absorbed by the HMO. The second-type contract is a "reasonable cost reimbursement" agreement whereby the HMO provides services to Medicare patients only so long as the costs are "reasonable." Qualifications to become an HMO include "enrollment of at least 25,000 with a 2-year history or, in rural areas, enrollment of at least 5,000 with a 3-year history." This law permits states to contract with HMOs for Medicaid services. A more detailed explanation of this new section of the law is available on request.

Any general discussion about health maintenance organizations must include a matter of deep interest and concern to organized medicine. . . national health insurance. A decision to enact some kind of national health insurance has apparently been made and passage of this type of legislation is expected in 1974.

In the preceding Congress, 13 proposals on national health insurance were introduced, five of which contained some or all of the elements required of an operating health maintenance organizaton.

What is status of HMOs in Michigan?

At least two proposals will be considered in the State Legislature this session for purposes of authorizing and regulating HMOs:

1. SB-182 was introduced on Feb. 21, 1973. No hearings have been held by the Senate Committee on Health and Social Services.
2. At the invitation of Donald Smith, MD, director, Governor's Office of Health and Medical Affairs, a subcommittee of the MSMS Committee on Legal Affairs reviewed a proposed legislative bill and offered several conceptual amendments. As of July 10, 1973, this bill had not yet been introduced.

Again, under generally accepted definitions, three organizations in Michigan may be classified as HMOs.

Comprehensive Health Services of Detroit in March, 1973, renewed a contract with the Michigan Department of Social Services to provide health services and benefits to Medicaid recipients. This contract expands the service area to include the City of Detroit and replaced the old contract which only provided services to 10,000 Medicaid recipients within the target area. A dispute has recently arisen between the MNCHP and the Model Neighborhood Agency which may affect future health services.

The Metro Plan was originally the Community Health Association. On Jan. 1, 1972, the boards of Blue Cross/Blue Shield assumed active management and control of CHA. If this operation is successful it is likely that there will be developed a variety of prepaid group practice programs throughout Michigan. As of July 11, 1973, MSMS is informed that Metro has been "talking" with the Michigan Department of Social Services to contract for providing medical services to Medicaid recipients. The pursuit of this objective "has not been aggressive on the part of Metro," MSMS was informed.

An HEW-sponsored neighborhood health center, known as The Berrien, Cass, VanBuren Health Center has contracted with the Michigan Department of Social Services for providing medical services to Medicaid recipients and may be classified as a quasi-HMO.

MSMS, through its Department of Government Relations, contributed valuable comments and suggestions to the Michigan Departments of Social Services, Public Health and the Insurance Bureau on acceptable and feasible HMO guidelines.

The situation in Michigan is voluble at this time. Presently there are twenty or more private and public community, neighborhood or family types of health centers now providing medical services with the potential to be classified as HMOs if certain contractual arrangements are consummated. For example, plans were announced at a University of Michigan Medical Center Alumni Association reunion of a proposed prepaid health care-health maintenance organization for Washtenaw County families. Purposes of the program are to serve 7,000 families in the county in addition to Blue Cross/Blue Shield plans, to train primary care physicians within the system and to do research on the effectiveness of this delivery system. In October, 1972, the United Community Services of Metropolitan Detroit approved a 1-year grant of $35,000 to Wayne State University Medical School to help facilitate the planning of a new health maintenance organization for Northeast Detroit residents. Provincial House, Inc., which operates nine nursing homes in Michigan, sought to operate a commercial hospital in the Lansing area to lay the foundation for a health maintenance organization. There has been opposition to this proposal from other hospitals within the Lansing area.

There are HMO ramifications under Public Law 91-623, the Emergency Health Personnel Act of 1970. That law established the National Health Service Corps and, thereby, added another dimension to medical care in Michigan. This law authorizes use of commissioned officers and other personnel of the U.S. Public Health Service to provide health care and services to persons residing in areas where there is a critical health manpower shortage. When physicians assume direction of these centers the likelihood of a link with larger medical institutions into HMO-type structures increases.

What advantages and disadvantages are advanced re:HMOs?

Current literature is replete with various views, comments and opinions regarding HMOs. Essentially, the advantages and disadvantages can be gleaned from the following views of proponents and opponents:

Proponent's Views

1. Health Maintenance Organizations, by virtue of the contractual assumption of responsibility for a defined range of services at a negotiated per capita rate, could have wide latitude (subject to legislation and regulations) to make their own professional decisions, establish priorities for patient care and exercise self-discipline in assuring the adequacy and quality of services provided.

2. Health Maintenance Organizations, as entities under contract to provide care for a defined population, could plan and justify their present and foreseeable needs for facilities, equipment, professional and ancillary manpower and other capital and operation costs.

3. Contractually stipulated performance reporting by a Health Maintenance Organization and competition could minimize the need for outside interference in the internal affairs of the Health Maintenance Organization. The Health Maintenance Organization concept could promote the emergence of self-regulating organizations which could slow the trend toward increasing federal intervention and domination.

4. Health Maintenance Organizations could assure the delivery of medical services more efficiently and effectively than fee-for-service providers, at a predetermined cost to government and to the consumer.

5. Health Maintenance Organizations could have economic incentives to utilize modern business techniques and new types of health manpower, to provide coordinated care, to avoid duplicating services and to utilize the least expensive care appropriate and adequate to a patient's needs.

6. Groups of physicians receiving capitation payments could, based upon peer decisions, remunerate their physician members on any basis including fee-for-service.

7. Health Maintenance Organizations could provide economic incentives to professionals to keep people well by emphasizing preventive services and ambulatory care. They could also increase the physicians' awareness of the cost implications of care wherever provided. By taking responsibility for a defined population at a predetermined capitation rate, a dis-incentive could be created for unnecessary services, taking the place of external regulation and utilization surveillance.

8. Health Maintenance Organizations could help to assure continuity, accessibility and availability of patient care.

Opponent's Views

1. The Health Maintenance Organization is exposed, just as are other health insurance mechanisms, to the risk of costs overrunning the contractually stipulated rate because of skewed and adverse enrollment selection, over-utilization from unforeseen catastrophic conditions or expenses or from incorrect budget estimates.

2. Prepaid group practice programs (and this could apply equally to other types of practices qualifying as HMOs) have frequently resulted in impersonal care, lengthy waits for appointments and an impression of deterioration in the quality of medical care provided.

3. The lack of mobility of the "captive" patient, i.e., freedom to select a physician outside the HMO, at a time when care is needed but not available, would be inimical to the provision of good quality medical care.

4. There is no guarantee that the formation of HMOs would result in greater accessibility and availability of medical care—two of the major stated justifications for the creation of HMOs.

5. Physicians in an HMO would function as "providers of services" in their relationship to government, and would be required to comply with regulations regarding administration and finance.

6. Fiscal soundness has first priority. Widespread "cutting of corners" would be to the disadvantage of the patient.

7. The entry of profit-oriented organizations into the health care industry could produce a crop of Health Maintenance Organizations out for a "quick buck."

8. There is reason to be concerned that the Health Maintenance Organization will attract a disproportionate enrollment of poor-risks.

President's page

Editor's note: Today's President's Page includes a valedictory message from John J. Coury, MD, of Port Huron, who concluded a year in the MSMS presidency Oct. 8 in Detroit, and a brief look at his successor, Brooker L. Masters, MD, of Fremont.

THANK YOU. I would be remiss if I left this great office and did not express my appreciation to the devoted staff that works so diligently and enthusiastically for our Michigan State Medical Society. It has been my opportunity to have observed and evaluated their devotion and sacrifices for many years. I can assure you they are second to none in all of the fifty state medical societies. Warren Tryloff, you and your staff have my deepest thanks and respect.

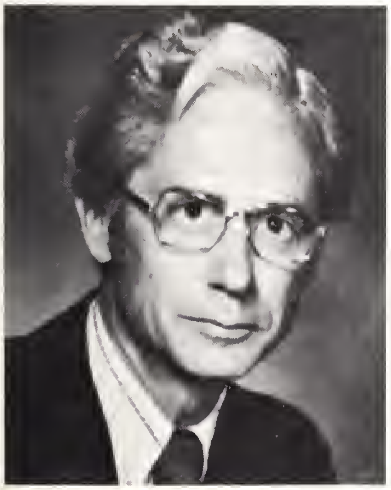
My appreciation goes also to all of the Councillors, elected leaders and many members of the House of Delegates and county societies for your assistance and advice. Without your aid my task would have been impossible.

And finally, my sincere thanks goes to my family, my partners, my colleagues and my patients for their tolerance and understanding. Without their understanding and sacrifices I would not have been able to experience what probably has been the most challenging, rewarding and fastest moving year of my life.

From all of you there has been devotion, sacrifice and care.

Devotion—sacrifice—care—that's what the game is all about!

John J. Coury, MD
MSMS Immediate
Past President



Brooker L. Masters, MD
MSMS President

BROOKER L. MASTERS, MD, steps into the presidency of the Michigan State Medical Society with a rich background of organizational activities and dedication to his profession and the community.

Doctor Masters has been a family physician in the Western Michigan community of Fremont for more than a quarter century and has been active in medical society programs for almost as long. A past president of Newaygo County Medical Society, he served MSMS as a Council member for nine years before he was named president-elect.

During the last year he has visited frequently with component medical societies and MSMS committees. One of his declared intentions as president is to step beyond the profession to tell community leaders of the progress being made in medicine and of the myriad complexities that contribute to health care costs.

A native of Plymouth, Ind., the new president was graduated from the Indiana University School of Medicine. He interned at Sparrow Hospital in Lansing and served as a major in the air force during World War II. Doctor Masters is a past chief of staff at Gerber Memorial Hospital in Fremont, where he established his practice in 1946. During 1957-1958 he served as medical director for Michigan Hospital Service.

Zip code 48823

Michigan Medicine invites reader comment on articles and other material appearing in the publication and on matters of general interest to physicians. The editors reserve the right to delete material from letters for publication. Letters must be signed for consideration for publication, but names will be withheld on request. Please address communications to Letters to the Editor Column, Michigan Medicine, 120 W. Saginaw St., East Lansing, Mich. 48823.

Experienced and somber medical judgment urged in tuberculosis treatment

Letter to the Editor:

Re: Tuberculosis...Changing Concepts
Vol. 71, No. 35, December, 1972
vs.
Tuberculosis...Why Our Concepts Have Changed
Vol. 72, No. 21, July, 1973

To those physicians who are still interested and confused regarding the present status of the treatment of tuberculosis, I urge that they again read in sequence the above articles.

It is apparent that there is an underlying medical-economic conflict involved regarding the method of treatment. Certainly such a practical conflict must be carefully considered, and the health of the individual case should not be jeopardized on the basis of statistics with the inference that all tuberculosis can be adequately treated on a non-hospital basis.

The closing statement advocating patients to take the initiative of not staying in the hospital and to forget they have a communicable disease further re-emphasizes the words of caution and the increased need for the physician and others responsible for the care of patients with tuberculosis to continue to use experienced and somber medical judgment in the treatment of this acute and chronic and contagious disease.

Very truly yours,

Chester S. Koop, MD
Chief, Medical-Surgical-Neurological Service
Traverse City State Hospital

Educator suggests new MM section for student articles

To the Editor:

I should like to suggest that a new section be added to *Michigan Medicine,* to which Michigan medical students and perhaps also interns and residents would be encouraged to contribute manuscripts. These could include reviews, case reports and results of original thoughts or research. Subjects of interest might relate to the basic sciences, the clinical sciences or the social sciences but might also be concerned with medical education, community resources or medical ethics. Such a section would, in addition, offer an opportunity for publication of abstracts from various Michigan meetings in which medical students and house staff present papers. At the present time these abstracts are frequently not available in the open literature.

The opportunity to contribute to *Michigan Medicine* would encourage medical students to write and would enable them to feel involved, at an early stage, in the "real world of medicine." At the same time, being able to read what youth has to say would add great interest, for many of us older physicians, to reading your journal.

Sincerely yours,

Theresa B. Haddy, MD
Assistant Professor
Department of Human Development
College of Human Medicine
Michigan State University, East Lansing

Beg Your Pardon

D. E. Chute, DO, was incorrectly identified in the August issue of *Michigan Medicine* in a "Countyscenes" article about the well-mother clinic held weekly in the General Division of Bay Medical Center in Bay City. Doctor Chute is the founder of the clinic, which is an effort of the Bay Medical Center's joint MD-DO staff in conjunction with the Bay-Arenac-Iosco County Medical Society.

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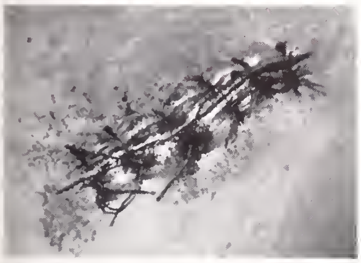

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Cover by Marvin Pearson, Lansing

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

MSMS opposes HMO advertising

"What is the attitude of MSMS about the possible advertising proposals of an HMO with which the Michigan Department of Social Services contracts for services to Medicaid patients?"

In response to this question, the MSMS Council has notified the state department that "MSMS is explicitly opposed to HMO advertising. MSMS desires that all specific instances be (1) brought to the attention of the appropriate enforcement authorities (2) brought to MSMS's attention for ethical review and possible disciplinary action if its members are involved."

A. Stewart Kerr, MSMS legal counsel, has written the state department to indicate that the solicitation of members by an HMO "may be violative" of the state law which prohibits all solicitation advertising by any physicians. Mr. Kerr further suggested, "We believe that this problem should be submitted to the Attorney General's office for an opinion and possible enforcement." Mr. Kerr explained, "In our view the Michigan courts would not allow physicians to do indirectly (through an HMO) that which they cannot do directly."

Nine physicians receive awards for leadership

Nine Michigan physicians received special recognition for leadership at the MSMS 1973 Annual Session in Detroit.

Four received the National President Award for service as president of a national medical organization. They are G. Jan Beekhuis, MD, of Detroit, president, American Academy of Facial Plastic and Reconstructive Surgery, Inc.; Robert Heavenrich, MD, of Saginaw, president, American Academy of Pediatrics; James W. Rae, Jr., MD, Ann Arbor, president, American Congress of Rehabilitation Medicine, and Stuart M. Gould, Jr., Ann Arbor, president, National Association of Private Psychiatric Hospitals.

The Flag Award for service as president of a nonmedical organization in Michigan went to Raymond E. Fuller, MD, of Grand Rapids, president, Michigan Heart Association; Charles O. Long, Jr., MD, of Lansing, president, Michigan Division, American Cancer Society; Walter A. Meier, MD, of Monroe, president, Michigan TB and Respiratory Disease Association; Robert E. Rice, MD, of Greenville, president Michigan Health Council, and Harry C. Saltzstein, MD, of Southfield, president, Michigan Chapter, American Medical Writers Association.

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Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.
Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.
Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.
(B)98-146-800-F (10/71)
For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

TA 9041

More than sleep.

your choice of sleep medication is wisely based on more than sleep-inducing potential

sleep with relative safety

Chronic tolerance studies have confirmed the relative safety of Dalm
(flurazepam HCl); no depression of cardiac or respiratory fun
was noted in patients administered recommended or higher d
for as long as 90 consecutive nights.

In most instances when adverse reactions were reported, they were mild, infrequent and seldo
quired discontinuance of therapy. Morning "hang-over" with Dalmane has been relatively infrequent. D
ness, drowsiness, lightheadedness and the like have been the side effects noted most frequently, particularly in the elderly and debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

sleep for 7 to 8 hou without need to repeat dosage

No sleep n
cation has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia pat
given one 30-mg capsule of Dalmane at bedtime, on average: fell asleep within 17 minutes, had fewer n
time awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to re
dosage during the night.

eep with
nsistency

Dalmane has been shown to be consistently effective even during consecutive nights of administration, with no need to increase dosage.

Dalmane (flurazepam HCl) is a distinctive sleep medication—a
odiazepine specifically indicated for insomnia. It is not a bar-
ate or methaqualone, nor is it related chemically to any other
able hypnotic.

When your evaluation of insomnia indicates the need for a sleep
ication, consider Dalmane—a single entity nonnarcotic, non-
iturate agent proved effective and relatively safe for relief of
mnia.

DALMANE®
(flurazepam HCl)
When restful sleep is indicated

One 30-mg capsule *h.s.*—usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.*—initial dosage for elderly or debilitated patients.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE

ROCHE LABORATORIES
Div., Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Opinion & Dialogue

"Prescription drugs – who should determine the maker?"

Dispenser of Medicine

Clifton J. Latiolais
President
American
Pharmaceutical
Association

"Too many doctors are indiffe ent to the economic consequences their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by form AMA Chief Executive F. J. L. Blasingame, M.D.

Doctor, are you indifferent...?

In discussing an anticipated ir crease in Blue Shield rates, Dr. Blas ingame's newsletter had this to say

"In general, it can be said, MD have given the impression they are not particularly concerned with the increase in cost of health care to th patients...

"True, an MD's training is primarily scientific, but in the real wo of practice, all of his scientific decisions have a price tag, or an econor impact. The economics of health c beckon the practitioner's attention Concern for economics of medicin

Maker of Medicine

C. Joseph Stetler
President
Pharmaceutical
Manufacturers
Association

When the pharmacist recommends that a drug product other th the one ordered be dispensed, the prescriber invariably permits the change when he feels the best inte ests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is nec sary for the prescriber to know tha the change is being contemplated, and to be in a position to consent o demur. Without that opportunity, t unilateral decision of the pharmac made in the absence of clinical kn edge of the patient, could expose h to needless risks, and in addition, jeopardize the relationship betwee the professions of Pharmacy and Medicine. In my view, there is noth in the pro-substitution argument th offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowle about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degr puts him at a disadvantage. Most often, a practicing physician will n expert knowledge of no more than

Advertisement

ould be an obligation of medical ractice . . .

“Medical societies ought to conuct continuing campaigns to point ut the substantial savings that could e realized thru deductible insurance nd protection for catastrophic illess. At the very least, they should, in e patients' interest, question the ctics of any insurance organization at raises health care costs by forcg policyholders to buy insurance ey may not need or want and probly won't ever use.

“Too many doctors are indifft to the economic consequences of eir decisions. Too many, for exmple, habitually hospitalize patients r the convenience of the MD. It's onsense to deny such habits exist . . .

“Doctors, thru their medical soeties, have unhesitatingly appealed their patients for support in the ght against government interference ith the private practice of medicine. nd the public in the past has reonded. It's time the American Medal Association and state and local edical societies paid off the debt by ecisive action to hold down the cost medical care.”

ost of Drugs

Insurance rates and hospital arges are only two factors in health care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists *are concerned*. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. “Drug product selection” simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the “White Paper on the Pharmacist's Role in Product Selection” from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

---

30 drugs that he selects to treat the ajority of conditions encountered in is practice. Moreover, the physian's choice of a specific brand is ased on his knowledge of the paent's medical history and current ondition, and his experiences with e particular manufacturer's roduct.

Some substitution proponents ave argued that the dispensing of a escription is a simple two-party ansaction between the pharmacist nd the patient, and that a substitutg pharmacist may avoid even a chnical breach of contract by simply otifying the patient that he is making e substitution. I would judge that w courts would be sympathetic ward a pharmacist who substituted ithout physician approval and who ndertook a legal defense that seeks make the patient responsible for e pharmacist's actions.

educed Prescription Prices?

Substitution advocates are ggesting to the consumer, and parcularly the consumer activist, that educed prescription prices could llow legalization of substitution. e have seen absolutely no evidence justify this claim. To the contrary, perience in Alberta, Canada, where bstitution is authorized, suggests the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands — of, say, ampicillin or tetracycline — or how long they keep “slow moving” products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor “corner cutting” pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advocates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, “The Medications Physicians Prescribe: Who Shall Determine the Source?” It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

Pharmaceutical
Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

ROCHE announces new BACTRIM™

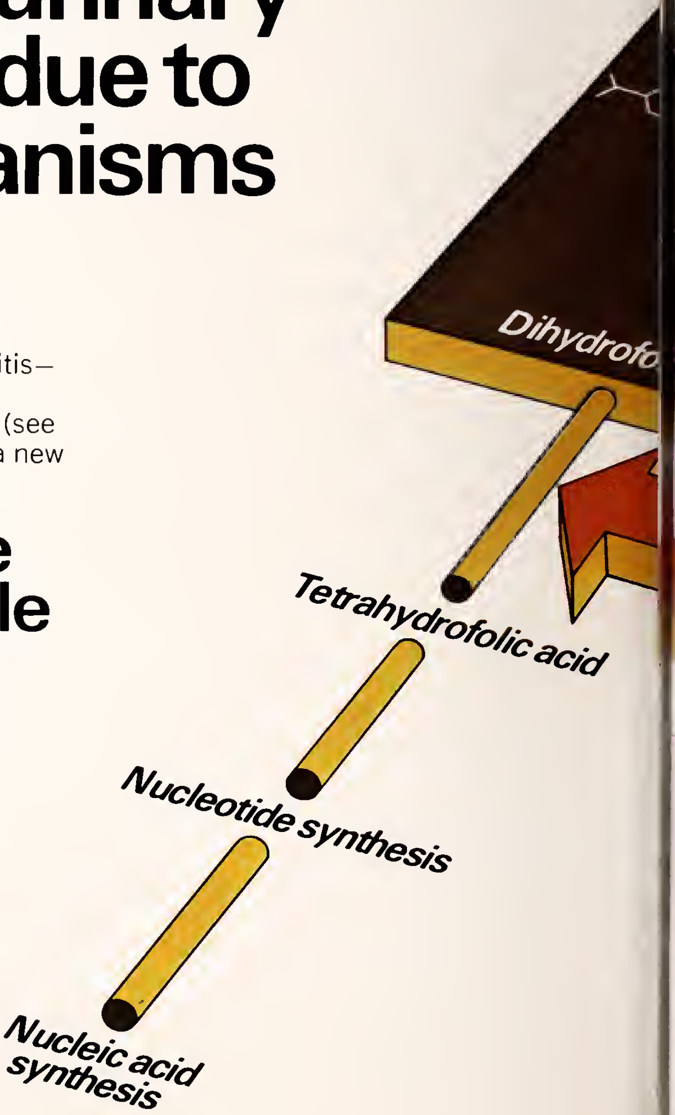
Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

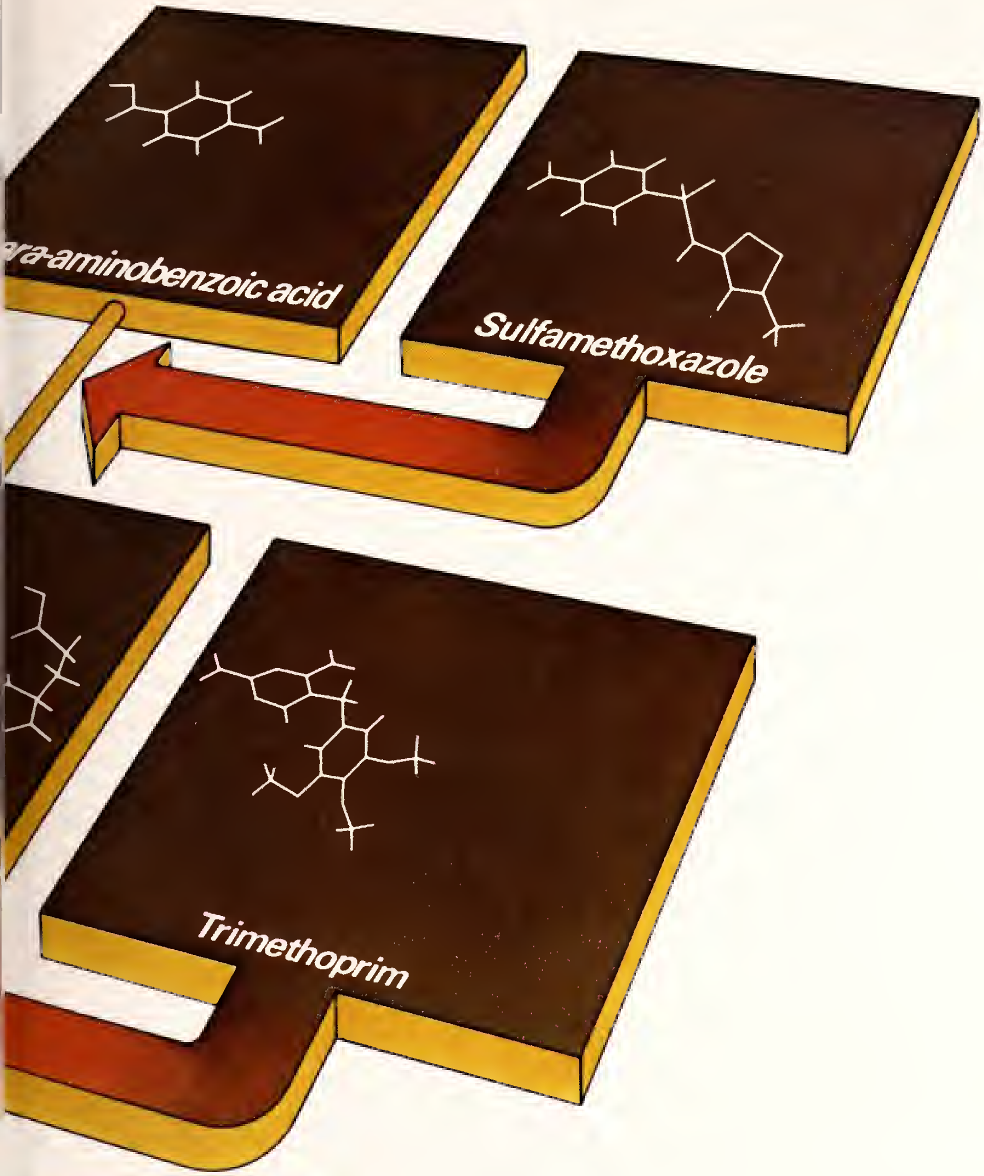
a new type of antibacterial for a two-pronged attack against chronic urinary tract infections due to susceptible organisms

Bactrim is highly effective in the treatment of these infections—primarily pyelonephritis, pyelitis and cystitis—when due to susceptible organisms. This efficacy is related to the unique mode of action against bacteria (see illustration), an action that, in effect, makes Bactrim a new type of antibacterial.

Bactrim interrupts the life cycle of susceptible bacteria

Unique mode of action interrupts the life cycle at two important points, thereby impeding the production of nucleic acids and proteins essential to these bacteria. These consecutive interruptions occur because sulfamethoxazole and trimethoprim resemble naturally existing substrates. By competitive replacement of these substrates, they inhibit further synthesis.




ra-aminobenzoic acid
Sulfamethoxazole
Trimethoprim

ROCHE

new **BACTRIM**™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

Before prescribing, please see complete product information on last page of advertisement.

Excellent clinical response in chronic urinary tract infections even with obstructive complications

A multiclinic, double-blind study* of response to a ten-day course of therapy in 471† patients with chronic urinary tract infections demonstrated the superiority of Bactrim. On the 10th day after initiation of therapy, 91.7% (of 168 patients) showed significant bacteriological response to Bactrim, compared with 81.2% (of 144 patients) to trimethoprim and 64.5% (of 155 patients) to sulfamethoxazole. More than half of these patients had obstructive complications.

Excellent response maintained

Bactrim proved equally impressive in maintaining this bacteriological response. In the above study, after a ten-day course of therapy with Bactrim, 68.4% of patients with chronic urinary tract infections *maintained* response for up to 42 consecutive days, compared with 59.7% with trimethoprim and 44.4% with sulfamethoxazole. These results are particularly noteworthy considering the number of patients with obstructive complications—cases regarded as being notoriously difficult to treat.

Prescribing considerations

Clinical Limitations: Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections. Not recommended for children under twelve.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period.

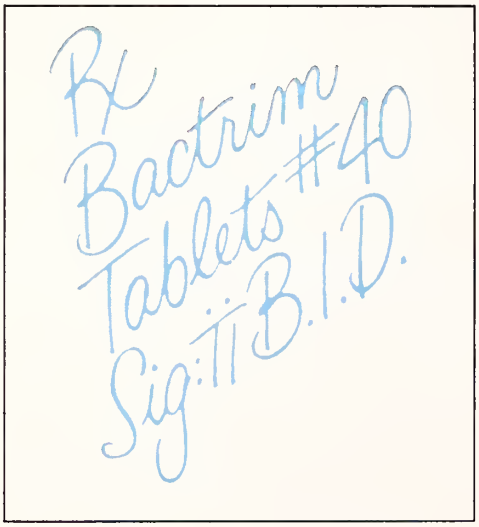
Warnings and Precautions: Both sulfamethoxazole and trimethoprim have been reported to interfere with hematopoiesis. Complete blood counts should be done frequently. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued. Bactrim should be given with caution to patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. Maintain adequate fluid intake. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Effects: Among the most common side effects are nausea, vomiting, rash, leukopenia and elevations in SGOT and creatinine.

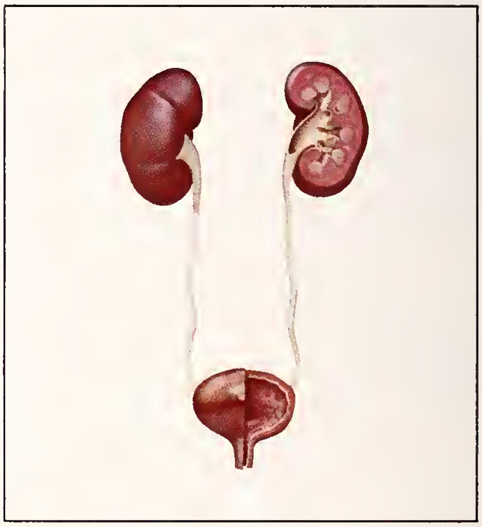
Usual adult dosage: two tablets every twelve hours for 10 to 14 days; no loading dose required.

*Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110

†4 patients not available for evaluation at day 10.



Rx
Bactrim
Tablets #40
Sig: ii B.I.D.



new BACTRIM™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, N J 07110

Complete Product Information:

Description: Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl)pyrimidine. It is a white to light-yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is N^1-(5-methyl-3-isoxazolyl)sulfanilamide. It is an almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

Actions: *Microbiology:* Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with *para*-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

In vitro studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

In vitro serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa.* The following organisms are usually susceptible: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis* and indole-positive proteus species.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms
(MIC—mcg/ml)

Bacteria	Trimethoprim alone	Sulfamethoxazole alone	TMP/SMX (1:20)	
			TMP	SMX
Escherichia coli	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
Proteus spp. indole positive	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
Proteus mirabilis	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
Klebsiella-Enterobacter	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

Human Pharmacology: Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. On repeated administration, the steady-state ratio of trimethoprim to sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma decreases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than are the concentrations in the blood. When administered together as in Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species).

***Important note:* Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.**

Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period (see Reproduction Studies).

Warnings: Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombopenia with purpura has been reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

Precautions: Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Reactions: For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

Blood dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

Gastrointestinal reactions: Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

C.N.S. reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

Miscellaneous reactions: Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

Dosage and Administration: Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

How Supplied: Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

Reproduction Studies: In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

BACTRIM™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

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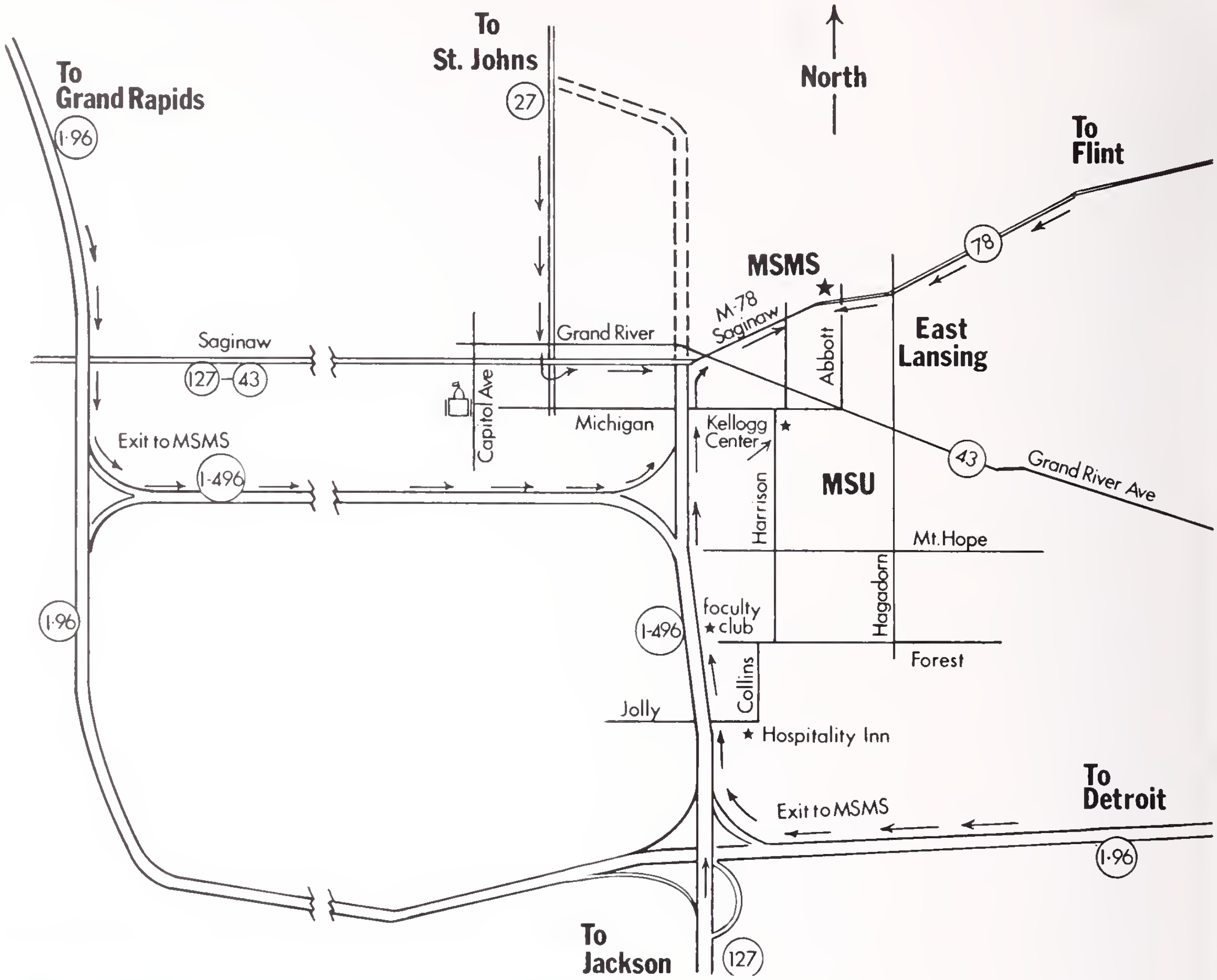
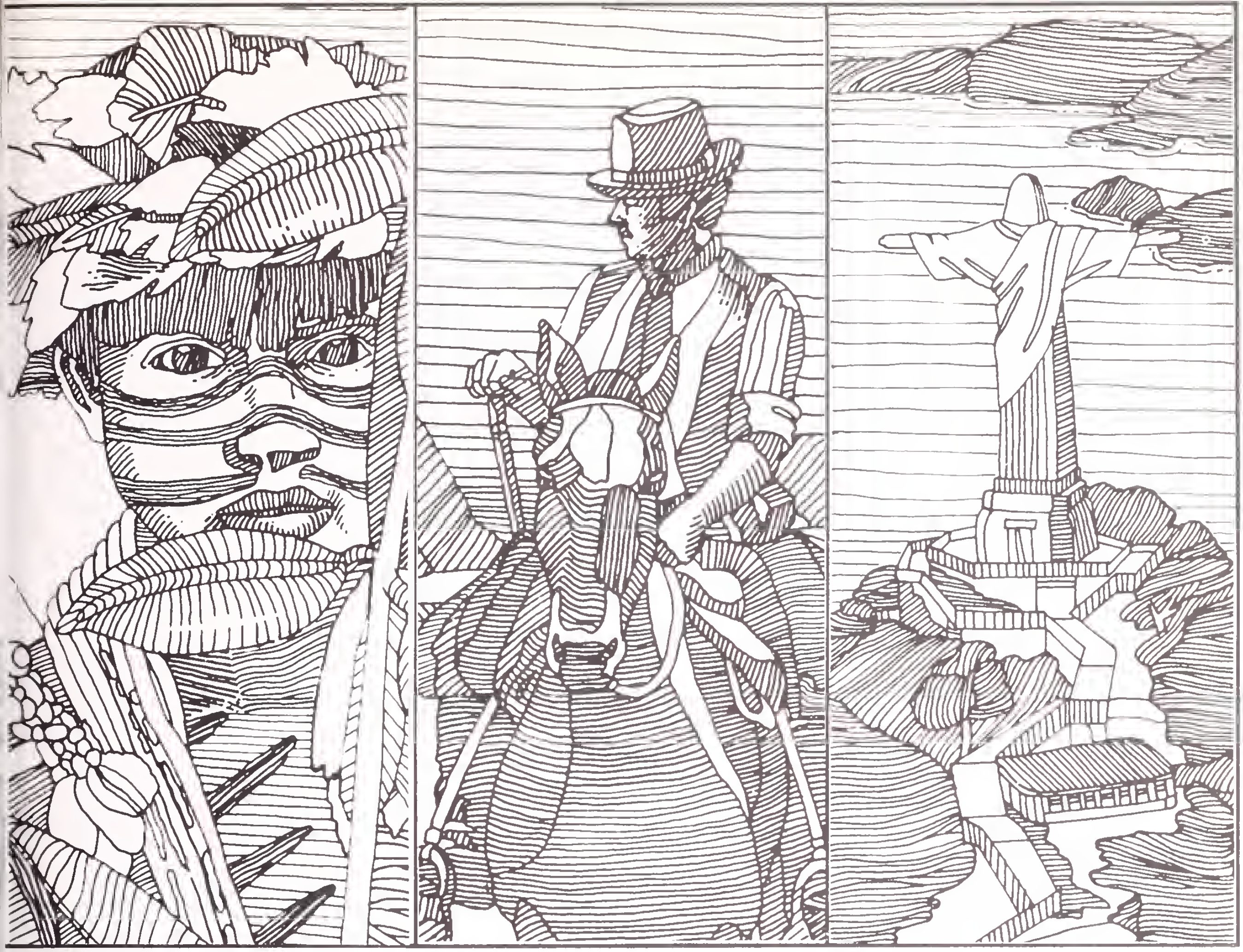
Nutley, N J 07110

Take these routes to visit MSMS headquarters


To Grand Rapids
I-96
To St. Johns
27
North
To Flint
78
MSMS
M-78 Saginaw
Abbott
East Lansing
Saginaw
127
43
Grand River
Capitol Ave
Michigan
Exit to MSMS
I-496
Kellogg Center
MSU
Harrison
43
Grand River Ave
Mt. Hope
Hagadorn
I-96
I-496
faculty club
Forest
Collins
Jolly
Hospitality Inn
To Detroit
Exit to MSMS
I-96
To Jackson
127

A surprising number of MSMS members have never visited the society's headquarters building in East Lansing despite visits to the Lansing area for dealings with government agencies or trips to Michigan State University to deposit student sons or daughters or watch the Spartans play football. The above map shows routes to the award winning building at 120 W. Saginaw St., East Lansing, from all the major roads leading into the Lansing area. The MSMS headquarters staff keeps regular business hours from 8:15 a.m. to 5 p.m. Monday through Friday. The building also is open many evenings and week-ends for committee meetings and other special events. The MSMS staff is eager to welcome physicians to the headquarters. Arrangements generally can be made for an evening or week-end visit with advance notice.



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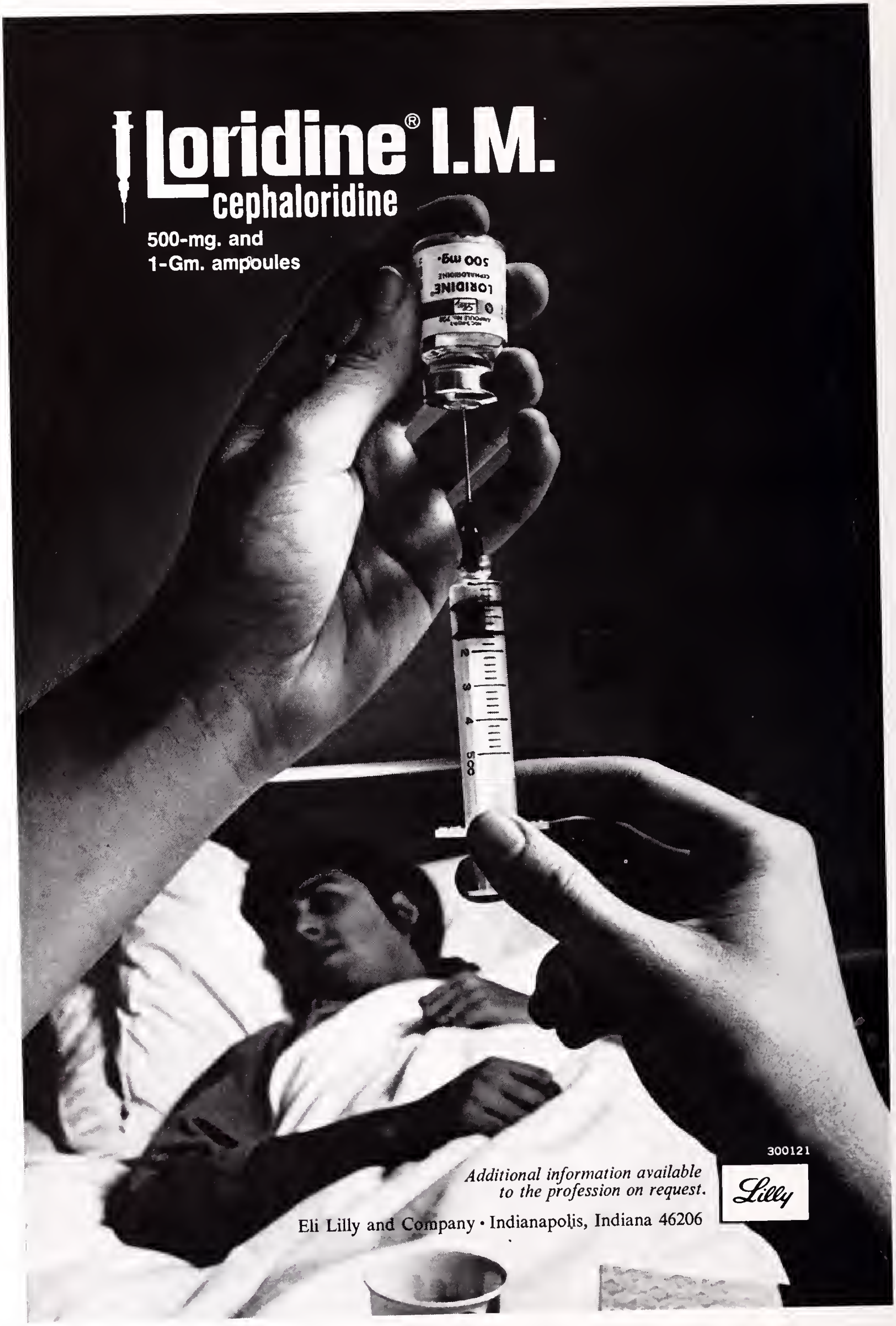

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Pulmonary alveolar microlithiasis

By Eshraghi Hossein, MD
Detroit

Pulmonary alveolar microlithiasis is a rare disease. About 80 cases have been reported in the literature. The characteristic features of this disease are (1) roentgenographic appearance of miliary disseminated lesions that are fine granules of calcium, (2) paucity of clinical symptoms despite a striking radiologic and pathologic picture, (3) familial incidence. There is no sexual predominance. The usual age at death has been between 30 and 50 years. Etiology is unknown although several possibilities have been proposed. Treatment is conservative and unsatisfactory.

Case Report

A 12-year-old white girl was seen by her physician for an upper respiratory infection associated with fever and cough. She was treated with antibiotic medication for about 10 days and responded well. Subsequently she was asymptomatic except for a persistent, dry cough for several weeks. Chest x-rays disclosed evidence of bilateral lung infiltration and the patient was admitted to the hospital.

There was no history of any previous chest x-rays or pulmonary problems. The patient's childhood development had been normal and she was able to keep up with other children in exertional activities. She had had an appendectomy, a tonsillectomy, measles, chickenpox and mumps in earlier childhood. There was no family history of any chronic respiratory disease.

Physical examination revealed a healthy looking, well developed and well nourished young female. Blood pressure was 120/82. General examination was entirely unremarkable, and the lungs revealed no abnormalities. The admitting diagnosis was possible sarcoidosis.

Laboratory studies revealed a normal urinalysis and negative serology. The blood count revealed a hemoglobin of 13.7 G. per 100 ml., hematocrit 41.5 mm., red cell count 4,89 million per cu. mm., white cell count 7,200 per cu. mm. with 35 percent polymorphonuclear cells, 8 percent band cells, 50 percent lymphocytes, 4 percent eosinophils and 3 percent monocytes. The sedimentation rate was 14 mm. in an hour. SMA-12 was normal except for elevation of alkaline phosphatase to 295 units (normal adult levels 30 to 85). Protein electrophoresis indicated slight elevation of gamma globulin to 17.1 percent (normal 9.7 to 14.3 percent).

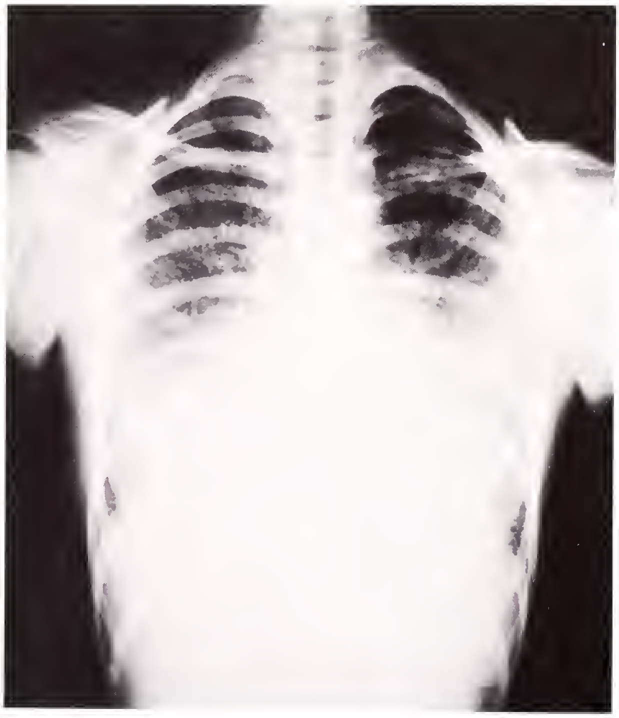

Fig. 1. Chest x-ray showing the miliary pattern of calcium densities.

Arterial blood gases were normal. Electrocardiogram revealed no abnormalities.

Pulmonary function studies were as follows:

Vital capacity 2079 ml.
Maximal voluntary ventilation 43.2 L/min.
Maximal expiration flow rate 2 L/min.
Minute ventilation 4.8 L/min. at rate of 18 breaths/min.
Oxygen consumption 375 mil./min.

(Continued)

Scientific articles

Doctor Hossein is a member of the house staff at Mount Carmel Mercy Hospital and Medical Center, Detroit.

Diffusion capacity 7.81 ml./min./mm.Hg.
Fractional residual capacity 2020 ml.
Expiratory reserve volume 783 ml.
Residual volume 1227 ml.
Total lung capacity 3306 ml.

The test showed a balanced loss of ventilation which probably was hypodynamic and/or restrictive in origin; diffusion was low. Chest x-ray is shown in Fig. 1. It was initially interpreted as extensive bilateral interstitial pneumonia, probably viral in origin or sarcoidosis. Subsequently it was recognized that the pattern was that of pulmonary alveolar microlithiasis.

Scalene node biopsy was nonspecific. Lung biopsy was performed and revealed pulmonary alveolar microlithiasis with interstitial pneumonitis and foreign body inflammatory reaction. The lung biopsy is shown in Figs. 2 and 3. When the diagnosis was established, one brother, one sister and parents were x-rayed and all of them were normal.

Discussion

Freidreich initially described this disease in 1856 and Holms in 1931 described it as pulmonary calcinosis. Mikailov from Bulgaria in 1854 showed the familial occurrence.[2] Sosman et al[12] did an excellent review of the literature and added 23 new cases of their own to the 21 known cases.

The paucity, or total absence of signs and symptoms in this entity despite extensive involvement of the lungs, is the corner stone to diagnosis.[11] Most of the cases so far described were discovered during routine chest x-rays, life insurance examinations, induction examinations for the armed forces or in tuberculosis surveys. Pulmonary sarcoidosis superficially may resemble pulmonary alveolar microlithiasis on chest x-ray, but there is nothing to suggest that this condition is related to pulmonary sarcoidosis.

In patients with symptoms, cough was the commonest. There was nothing unusual about the cough in the early stages of the disease. The cough may become productive in later stages of the disease, when heart failure and pulmonary congestion are superimposed in the pulmonary deficiency. These patients only rarely have hemoptysis.

Symptoms are more common in older than in younger individuals. The most frequent late symptoms are those of pulmonary insufficiency, shortness of breath on exertion, increasing dyspnea, cyanosis, cough, increased sputum, occasionally clubbing of the digits and eventually heart failure due to cor pulmonale. In all cases, symptoms were related to the pulmonary system except for the patient of Cotzee that had abdominal pain due to involvement of paravertebral sympathetic ganglia by calcium deposition.

Physical examination has been most disappointing, the findings being uniformly normal in the earlier stages, and nonspecific in the advanced cases. However, the negative physical examination and the paucity of symptoms associated with the striking x-ray picture are an important feature of this disease. Almost any other disease process with such extensive involvement of the lungs would be expected to produce marked symptoms, with the possible exception of sarcoidosis.

The radiologic features are considered to be quite characteristic. On chest x-ray, both lungs are filled with sand-like mottling, obviously of calcium density. It suggests a snowstorm, or perhaps more correctly, a sandstorm. Fine grains of sand are uniformly distributed throughout both lung fields, more marked in the bases of the lung and in the lateral portions, as would be expected from pure volumetric considerations.

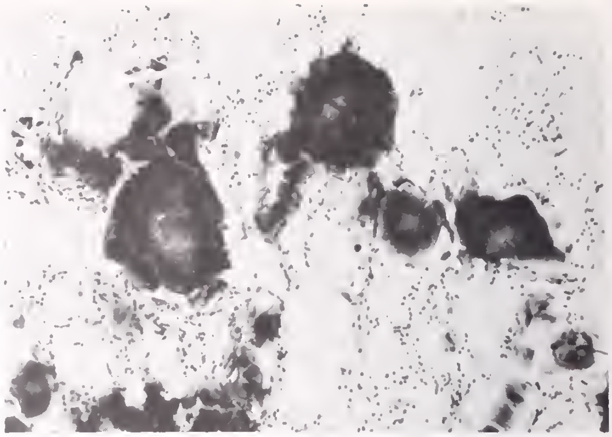

Fig. 2. Lung biopsy showing intra-alveolar pulmonary microlithiasis.

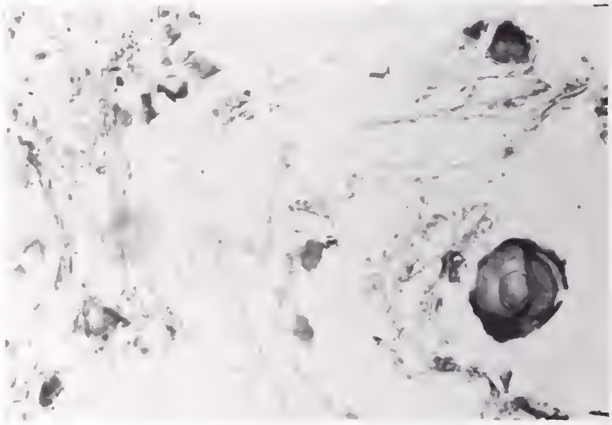

Fig. 3. Lung biopsy showing the laminated pattern of a calcium deposit.

Individual lesions appear granular, sharp in outline but irregular in shape, of calcific density, usually less than one millimeter in diameter and best recognized and appreciated by using a low power magnifying glass. These granular opacities often obscure the cardiac outlines, the diaphragm, and the normal vascular shadows in the lung. The calcium density of these lesions and their distribution are the key to diagnosis.[6] It is possible that in the preliminary stages of the disease, a noncalcified matrix fills the alveoli before deposition of calcium and phosphate salts occurs. This would produce shadows of soft tissue density indistinguishable from any miliary pulmonary lesions. To differentiate this disease from other miliary diseases, overexposed or overpenetrated x-rays are necessary to define lung details and to bring out some of the underlying structures.

Pleural surfaces are outlined by continuous deposits of dense calcium salts, more evident in the right lung, and laterally. Follow-up of patients reveal that there is no decrease in the calcium densities with the passage of time, and there is no visible effect on the roentgen appearance by any form of therapy so far attempted. The lesions become progressively denser, apparently coarser and more coalescent; large emphysematous blebs develop. These lesions are limited to the lung, except for the case of Cotzee[14] that had similar lesions in the paravertebral sympathetic ganglian and testis.

Metallic stannous oxide may cause a picture similar to this condition, but the lesions of stannosis are coarser, of metallic density, and differ in distribution. Berylliosis may simulate pulmonary alveolar microlithiasis because of the fine diffuse nodularity of the lesions and the ground-glass appearance. These lesions, however, are granulomatous and do not contain any calcium density.

Pulmonary hemosiderosis may resemble microlithiasis but the pulmonary hemosiderosis is frequently associated with mitral valve disease. The same difficulty may be encountered in the separation of this pulmonary microlithiasis miliary processes affecting the lungs, such as miliary tuberculosis,[4] miliary metastases, lymphangitic metastases, bronchiolitis, acute pulmonary edema, idiopathic pulmonary fibrosis (Hamman-Rich Syndrome), chronic interstitial organizing pneumonitis, miliary mycoses (histoplasmosis, cryptococcosis, torulosis) lymphatic leukemia, pulmonary eosinophilic granulomatosis, occasional cases of polycythemia and pneumococcioses, (berylliosis, silicosis, asbestosis, bagassosis).

The laboratory findings in pulmonary alveolar microlithiasis are remarkably few. Most routine studies are within normal limits. In advanced stages of the disease, there may be compensatory or secondary polycythemia due to loss of pulmonary function. Blood counts, blood proteins, serum phosphorus and calcium, urinalysis, sputum, gastric washings, bronchoscopic aspirations and cardiac catheterizations have been within normal range. Electrocardiograms may have evidence of right ventricular hypertrophy in advanced symptomatic cases.[3] Pulmonary function tests in asymptomatic cases may be within normal limits. There may be reduced lung compliance because of lung stiffness, uneven gas distribution and uneven distribution of pulmonary blood flow. Total lung capacity and forced vital capacity may be decreased. Airway obstruction may be evidenced by decreased forced expiratory volume. There may be an increased ratio of physiological dead space to tidal volume. Some patients may show reduced diffusing capacity and arterial 0^2 may be reduced.[9] The overall result of pulmonary function tests are compatible with restrictive and more or less obstructive lung disease.

The primary pathologic involvement is found in the lung. Pleural surfaces are free of adhesions and inflammatory reactions, but the sand-like particles can be seen and felt immediately beneath the pleura. Emphysematous blebs may be present. The lungs are hard and are cut with some difficulty. They are gritty and do not collapse on removal from the body. They are heavier than normal. In some cases, the lungs sink in water. The apical portions of the lungs are softer, semi-compressible and sometimes emphysematous, while the bases are stony and less compressible. In cutting the lung, there is a sandpapery feeling to the surfaces of the sections. Purulent exudates, infections, consolidations and hemorrhages have been conspicuous by their absence. Myriads of tiny spots or granules containing calcium are present. On microscopic examination, 25 to 75 percent of the alveoli contain laminated concretions called stones or microliths. Although the alveolar wall seems to be normal in some sections, interstitial tissues show either fibrosis, cellular infiltration or both. It seems that the tissue reaction and the number of stones increases with age. These calculi and concretions are very similar to the corpora amylacia found in the prostate gland. They usually vary in size from 0.02 to 0.3 cm. in diameter and may have radial lines suggesting cracks crossing the circular laminations. Some have central nidus that may be tissue debris. The descriptive term, onion skin appearance, is quite appropriate for these stones in which no cellular remnant can be identified. Giant cells are common, but seem to be haphazard in location. No organisms can be identified. Autopsies have failed to show any primary disease of the pulmonary vascular system, but there may be secondary changes from the inflammatory reactions resulting from the presence of innumerable foreign bodies.

(Continued)

The gross pathology in this condition is apparently limited to the lungs. No consistent involvement of other organs has been found. The heart exhibits hypertrophy and dilatation of the right ventricle in those patients who developed right heart failure. Because of repeated suggestions that the disease may be due to some disturbance in calcium metabolism studies of the endocrine organs, the skeleton[7] and the lymphatic systems have been performed repeatedly, with normal results. As previously noted, Cotzee reported a case with involvement of the sympathetic nervous system and gonads.

Chemical analysis of the lung shows a marked increase in total solids and in the ash content of the lungs, reaching as much as twelve times the usual amount. Predominant elements are calcium and phosphorus with smaller amounts of magnesium and aluminum and traces of silicon and iron. Analysis for iron or silicon would differentiate this condition from hemosiderosis or silicosis where confusion might exist.

The chemical structure of the liths consists mostly of calcium phosphate and calcium carbonates.

With respect to etiology, occupational exposure has been suggested as a possibility but no compatible histories have been noted in reported patients. The discovery of several cases in young children makes it highly improbable that this disease has anything to do with such exposure. A few cases have been attributed to the inhalation of snuff from Thailand,[8] but no proof has appeared. Fungi and yeasts as causative agents have been considered, but extensive laborious investigations have not revealed any such organisms.

Several patients have had repeated attacks of pneumonia or pleural pain that suggest recurrent infection as an etiologic possibility, but usually pulmonary symptoms follow the onset of the condition, rather than precede it. A mitral valve lesion was present in one reported case and was considered coincidental.[12-5]

Granulomatous disease as an etiologic factor has been mentioned in the literature, but has been refuted on the basis of histopathologic investigation. Disorders of calcium metabolism have been thoroughly investigated as a possible cause, but no confirmatory evidence has been found.

Environment apparently has no causal relationship since the disease is found in rural as well as urban communities, and in patients living at different altitudes.

Tany[4] et al (and others[12]) reported since pulmonary alveolar proteinosis and pulmonary alveolar microlithiasis are both intra-alveolar processes, they may represent the variants of a hereditary disorder.

In over one-third of the reported patients, there is involvement in other family members. The pattern suggests an autosomal inheritance, and because of the rather high family incidence, all close family members of patients should have chest x-rays.

There is no difference in sex incidence. Racial factors seem to play no role. The disease has been reported in Norwegian, English, Scottish, Irish, French, Italian, German, Bulgarian, Hungarian, Spanish, Negro, Japanese, Armenian, American and Mexican individuals.

The age distribution is fairly wide, but the majority of patients has been under 53 years of age. The oldest patient, aged 72, is the doubtful case of Bernet et al, the youngest, a girl of 4 reported by S. P. Yang.[13]

It seems that the degree and amount of change depend somewhat upon the age of the patient and the extent of involvement when the condition is first recognized. The younger the patient at the time of discovery of the disease, the longer the lifespan of that patient. Although this condition is one of slow progression, constant increase and extensive involvement of the lungs by the calculi and reactions to them ultimately end the life of these patients by virtue of induced respiratory insufficiency or congestive heart failure secondary to cor pulmonale.

There is no satisfactory treatment, but prompt therapy of complicating pulmonary infections is essential because many patients die of infection. Steroids have been of no value, nor have chelating agents.

Summary

The clinical history of patients with pulmonary alveolar microlithiasis has been described and the entity briefly reviewed.

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(Continued on page 700)

Combined treatment of hypertension with vasodilatation and beta-adrenergic blockade

By Lennart Hansson, MD
Andrew J. Zweifler, MD
Ann Arbor

Treatment of moderate to severe hypertension has for several years relied upon diuretic agents in combination with drugs that interfere with adrenergic nervous functions. Although several of the presently used adrenergic blockers, e.g., guanethidine (Ismelin^R), must be regarded as potent antihypertensive drugs, their usefulness is often limited because of disturbing side effects. Specifically, reduction of alpha adrenergic tone commonly causes postural hypotension, impairment of sexual function and increased frequency of bowel movements. Other drugs with a similar mode of action but with additional central effects, e.g., methyldopa (Aldomet ^{R}), clonidine (Catapres ^{R}) and reserpine, may cause sedation and tiredness as well.

Attempts have been made to use drugs with a direct vasodilator action, but without immediate effect on the autonomic nervous system, e.g., hydralazine (Apresoline ^{R}). This is a logical approach as most forms of established hypertension are characterized by an increased total peripheral vascular resistance.[1,2] However, the hypotensive effect of vasodilators, when used alone, is usually mild and often transient. This is due to a baroreceptor-mediated increase of sympathetic tone causing an elevation of heart rate and cardiac output. Thus the increase of cardiac output largely cancels the hypotensive effect resulting from the peripheral vasodilatation and in addition the patient may experience disturbing side effects such as palpitations.

The fairly recent introduction of specific beta adrenergic blockers, e.g., propranolol (Inderal ^{R}) into clinical use has drastically changed this picture. Not only has propranolol been shown to be an effective antihypertensive agent when used alone,[3-6] but its ability to reduce adrenergic impulses to the heart has been demonstrated to be of value in patients who are being treated concomitantly with vasodilators. Several clinical trials have shown that propranolol plus a vasodilator is a useful combination for controlling hypertension with a minimum of side effects.[7-9] For this reason the present investigation was started, aimed at studying the effectiveness of this combination in patients whose blood pressure had not been adequately controlled with conventional hypotensive drugs and who were seriously troubled by the side effects of conventional therapy.

Material and Methods

Thirteen patients were studied. There were 11 men and two women, whose average age was 47 years, with a range of 29 to 60. Twelve patients had essential and one had renovascular hypertension.

All patients had moderate to severe hypertension, with Keith-Wagener-Barker Grade II retinopathy present in 11 patients (three previously Grade III). Left ventricular hypertrophy on EKG or chest x-ray was demonstrated in three patients, while eight patients had serum creatinine levels greater than 1.2 mg/100 ml (average 1.6 mg/100 ml, range 1.0-2.7). Hypertension had been known in all of the patients for several years and all were on active treatment with two antihypertensive drugs or more when entered into the study. For complete details see Table I.

Dosage of propranolol and hydralazine were determined according to blood pressure and heart rate. The average dosage of propranolol was 182 mg/day (80-320) and the average dosage of hydralazine was 161 mg/day (75-400). In most patients previous therapy with diuretics was continued. In five patients treatment with methyldopa, guanethidine and dibenzyline, respectively, was continued with the same or reduced dosage as prior to the study.

The study was performed on an outpatient basis and all patients were seen in the hypertension clinic at two-six week intervals. Average duration of treatment was seven weeks. Statistical comparison of blood pressure before and during treatment with propranolol and hydralazine was made with Student's t-test for paired observations.

(Continued)

The authors are affiliated with the Department of Internal Medicine, Hypertension Section, University of Michigan Medical Center, Ann Arbor.

Their research was supported in part by a grant from the Michigan Heart Association.

Results

As can be seen in Table II, the average recumbent blood pressure fell from 170/115 mm Hg to 143/93 mm Hg. Thus the reduction of systolic blood pressure was 27 mm Hg ($p<0.01$) and of diastolic blood pressure 22 mm Hg ($p<0.001$). Standing blood pressure was reduced from 148/104 mm Hg to 132/95 mm Hg (16 mm Hg systolic, $p<0.02$ and 9 mm Hg diastolic $p<0.05$). The heart rate fell from 81 to 76 beats/minute (not significant).

Five patients who had experienced postural hypotension on previous therapy were completely relieved from this, while four patients spontaneously mentioned that their previous drowsiness and fatigue had disappeared after the change of treatment.

Discussion

The results reported here reveal that substitution of the combination of hydralazine and propranolol for a previously inadequate or disabling sympathetic blocking agent provides better control of hypertension. They also indicate that the addition of this combination to a relatively ineffective therapeutic program results in improved blood pressure control. Standing blood pressure was relatively higher during combined hydralazine-propranolol therapy than with prior treatments.

The findings in this study are consistent with those reported previously[7,9] and are not surprising since, logically, the combination of sustained vasodilation and beta adrenergic blockade should lower blood pressure in hypertensive patients.

As increased peripheral resistance is characteristic of established hypertension, hydralazine is well-suited for treatment of this disorder since it has a direct relaxing effect on the smooth muscle cells of the resistance vessels.[10] Administration of propranolol provides blockade of baroreceptor-mediated increase of adrenergic outflow to the heart, thereby preventing a compensatory rise of cardiac output which could nullify the hypotensive effect of vasodilation. Additionally, it is quite likely that the hypotensive effect of

Table I

PATIENT DATA

Patient No.	Sex	Age	Type of Hypertension	LVH on EKG or Chest X-ray	Serum Creatinine mg/100 ml	Initial Therapy mg/day
1	F	33	Essential	No	1.0	A 1500, D
2	M	52	Essential	No	1.3	C 0.6, Di 40, P 160
3	M	47	Essential	No	1.1	Di 20, P 160
4	M	48	Essential	Yes	2.5	A 750, G 62.5, D
5	M	45	Essential	No	1.2	A 1500, H 150, D
6	M	39	Essential	No	2.1	P 160, D
7	M	52	Essential	Yes	1.8	C 0.8, D
8	M	54	Essential	No	1.2	C 0.3, D
9	M	57	Essential	No	2.7	A 1000, P 160, D
10	M	60	Renovascular	No	1.8	A 1000, D
11	M	36	Essential	Yes	2.1	C 1.8, G 50, D
12	M	59	Essential	No	1.4	G 62.5, D
13	F	29	Essential	No	1.2	C 1.6, D

A = Alpha methyldopa (Aldomet)
C = Clonidine (Catapres)
D = Diuretic
Di = Dibenzyline
G = Guanethidine (Ismelin)
H = Hydralazine (Apresoline)
P = Propranolol (Inderal)

Table II

BLOOD PRESSURES BEFORE AND DURING COMBINED VASODILATATION AND BETA BLOCKADE

	On Initial Therapy						On Propranolol and Hydralazine							
Patient No.	Recumbent Syst.	Recumbent Diast.	Standing Syst.	Standing Diast.	Heart Rate	Recumbent Syst.	Recumbent Diast.	Standing Syst.	Standing Diast.	Heart Rate	Propranolol mg/day	Hydralazine mg/day	Diuretic
1	156	108	130	110	96	130	90	122	108	80	160	150	No
2	169	106	130	98	52	143	100	142	110	98	160	75	Yes
3	150	121	110	84	89	122	88	115	82	88	160	100	No
4	193	117	158	110	89	149	90	124	88	64	160	200	Yes
5	194	123	140	110	108	165	101	156	100	92	80	150	Yes
6	160	120	180	120	64	150	96	146	90	72	160	240	Yes
7	170	120	162	105	75	175	124	172	120	76	320	200	Yes
8	138	88	142	98	76	140	65	129	78	56	160	100	Yes
9	171	120	168	100	72	170	99	148	98	76	160	100	Yes
10	190	130	145	105	102	140	98	104	88	96	80	400	Yes
11	180	130	155	125	82	123	91	125	100	80	320	200	Yes
12	220	120	170	100	84	130	80	130	80	76	320	100	Yes
13	118	95	120	90	76	124	92	104	90	89	120	75	Yes
MEAN	170	115	148	104	81	143	93	132	95	76	182	161	
± S.E.M.	7.1	3.5	3.5	3.1		5.0	3.7	5.6	3.5				

Systolic BP reduction recumbent 27 mm Hg, $p<0.01$
Diastolic BP reduction recumbent 22 mm Hg, $p<0.001$

Systolic BP reduction standing 16 mm Hg, $p<0.02$
Diastolic BP reduction standing 9 mm Hg, $p<0.05$

propranolol itself is added to that of hydralazine. Thus this combined treatment offers a potent, and from a physiological standpoint, rational approach to the treatment of hypertension. Furthermore, the advantage of not impairing alpha adrenergic tone leads to the elimination of disturbing side effects such as hypotension in the standing position, failure of ejaculation and erection, and hypotension during physical activity. Several of our patients spontaneously noted the complete disappearance of the above-mentioned symptoms.

No side effects were observed in any of the patients in the present study and judging from published data, the frequency of side effects can be expected to be low. The SLE-like syndrome following hydralazine treatment is rarely seen if the daily dosage is kept below 200 mg daily. As already mentioned, the cardiovascular side effects of hydralazine, e.g., tachycardia, palpitations and the possible provocation of angina pectoris, are all controlled by the concomitant administration of propranolol.

The tendency toward fluid retention which occurs frequently in patients treated with all potent vasodilators is usually controlled by standard doses or oral diuretic agents. Rarely is there a need for more potent diurectics, e.g., furosemide.

Propranolol by itself is contraindicated in patients with asthma, cardiac decompensation and atrio-ventricular block. Unwanted effects that occasionally have been observed are mild gastrointestinal disturbance manifested by nausea or loose bowels and sometimes mild sedation.[3,4,5]

Our impressions of the combined use of propranolol and hydralazine in hypertension are that the antihypertensive potency compares favorably with any other form of treatment and that the side effects are considerably fewer and of a milder type than those of conventional potent antihypertensive drugs. It should be noted, however, that the use of propranolol in hypertension is still investigational.

Summary

Thirteen patients with moderate to severe hypertension were treated with propranolol (Inderal R) and hydralazine (Apresoline R). Although all patients initially were receiving two

(Continued)

MICHIGAN
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MONTHLY SURVEILLANCE REPORT

CASES OF CERTAIN DISEASES
REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH
For the five-week period ending Aug. 31, 1973

	1973 This 5-Week Period	1972 Same 5-Week Period	1973 Total To Above Date	1972 Total Same Date	Total Cases for 1972
Rubella	54	34	1,823	1,263	1,460
Cong. Rubella Syndrome	0	0	1	0	1
Measles	71	30	4,353	1,976	2,353
Whooping Cough	3	12	47	75	116
Diphtheria	0	0	0	1	1
Mumps	58	73	3,893	2,693	3,729
Scarlet Fever & Strep Sore Throat	1,200	416	15,285*	8,064	13,304
Tetanus	1	0	1	1	2
Poliomyelitis (paralytic)	0	0	0	0	1
Hepatitis	396	360	2,606	2,888	4,322
Salmonellosis (other than S. typhi)	100	96	462	548	781
Typhoid Fever (S. typhi)	2	1	8	6	7
Shigellosis	64	67	407	392	574
Aseptic Meningitis	128	49	233	101	266
Encephalitis	21	15	115	64	108
Meningococcic Meningitis	3	7	39	39	55
H. Influenza Meningitis	1	10	70	55	81
Tuberculosis	146	152	976	1,159	1,609
Syphilis	331	460	2,922	3,356	4,815
Gonorrhea	3,368	2,750	19,739	15,716	24,728

Information can be supplied by the local health department on the local incidence of disease.

*corrected total

Maurice Reizen, MD, Director
Michigan Department of Public Health

HYPERTENSION/Continued

or more potent antihypertensive agents, significant reductions of blood pressure were achieved. Recumbent blood pressure fell from 170/115 mm Hg to 143/93 mm Hg. Standing blood pressure fell from 148/104 mm Hg to 132/95 mm Hg. No side effects were observed; on the contrary, several patients reported that side effects caused by the previous therapy had disappeared.

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Percutaneous internal jugular vein catheterization

By K. Z. Masud, MD
K. J. Forster, MD
Saginaw

Monitoring of the Central Venous Pressure (CVP) is now an established aid in the Volume replacement of critically ill patients.

Vein Sites used for the placement of CVP catheter consist of the following:

Antecubital This approach is the most accessible; however it occasionally requires a cutdown to facilitate insertion. Deflection of the catheter tip by one of the many valves in the peripheral veins is a definite disadvantage in using this approach.

Introducing a CVP catheter into the antecubital site of a patient undergoing surgery requires difficult maneuvering.

Subclavian This approach introduces the catheter directly into a central vein and reduces the possibility of catheter tip deflection. However, complications like pneumothorax and hemothorax have been reported by Schapira and Stern.

External Jugular Vein This route provides an easy approach, but at times the catheter cannot be threaded past the ostia of various tributaries.

Internal Jugular This is in most instances the easiest approach, resulting in minimal complications.

We started using the internal jugular vein puncture not only for CVP placement but also for long term I.V. therapy and I.V. infusions in shock patients when the peripheral veins are collapsed.

Technic (Figures 1-4)

Percutaneous catheterizaton is preferably performed in the right vein as thoracic duct injury has been reported by Khalil after left vein puncture. In addition, the approach to superior vena cava and right atrium is easier through the right internal jugular vein. The patient's head is turned to the opposite side and a slight Trendelenburg tilt is given to the bed or the OR table. If the patient is awake he is asked to perform a Valsalva maneuver. In case of an anesthetized patient a sustained positive pressure is applied over the breathing bag to achieve increased intra-thoracic pressure. We use an Intra Medicut® set. The 14 gauge extracath mounted over a needle is used for venipuncture. The puncture is made in the center of the triangle formed by the two heads of the sternoclidomastoid and the clavicle. The extracath is directed caudad and slightly lateral and posterior. The slight lateral angulation avoids the possibility

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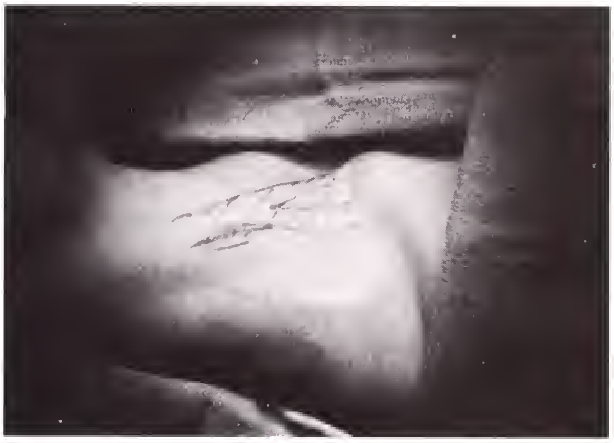

Figure 1

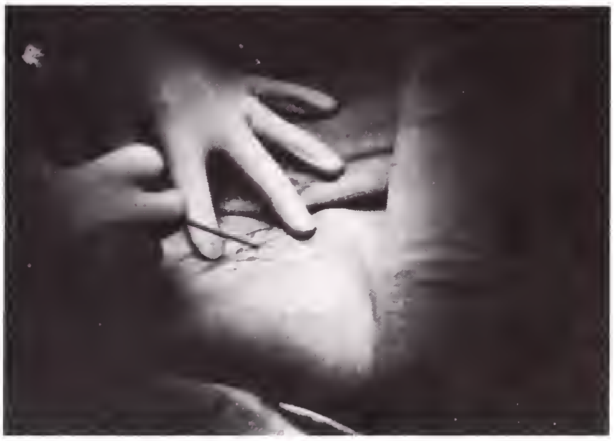

Figure 2

The authors are affiliated with the Department of Anesthesiology, St. Mary's Hospital, Saginaw.

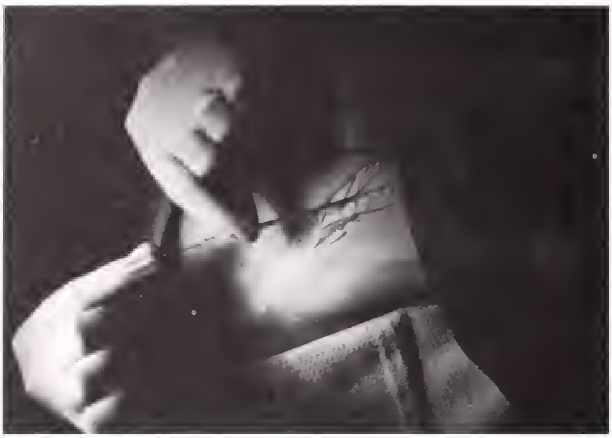

Figure 3

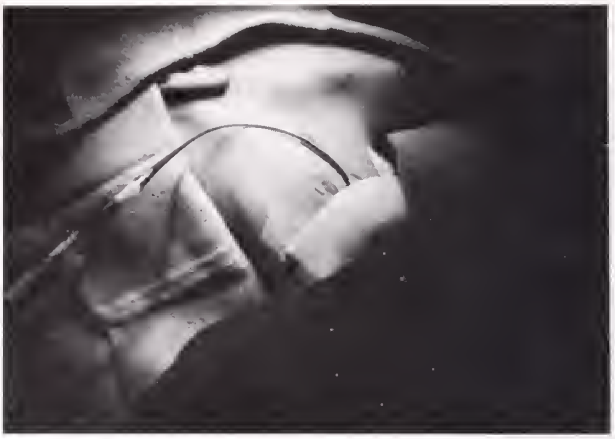

Figure 4

of puncturing the carotid artery. A negative pressure is maintained on the syringe and as soon as the dark venous blood is observed in the syringe, further insertion is stopped and the extracath is then slid over the needle and into the vein. The needle is then withdrawn and if a Trendelenburg position with positive pressure has been maintained, blood would be seen coming out through the catheter. The 16 Gauge catheter is then threaded through the extracath and into the superior vena cava and the right atrium. Antibiotic ointment is then applied at the site of puncture and the catheter secured either by a suture or by ½ inch tape wound around the catheter and taped firmly to the skin.

We have performed this technic in over one hundred patients in the past two years without any complications. The catheter, on occasions, was left in site for periods extending to one week. Inability to introduce a CVP catheter at this site occurred only once and that failure was in a patient with extensive subcutaneous emphysema extending over the neck and shoulder area.

Lately we have been using the right internal jugular venipuncture by a 14 gauge extracath to introduce a double lumen Swan-Ganz Catheter in the Pulmonary artery. This not only avoids a venous cutdown with its accompanying complications, but also allows the use of 60 cm long Swan-Ganz Catheter in most adults.

Considering the easy accessibility to the internal jugular vein even in severely hypovolemic patients, minimal complications and simplicity of technique, more frequent use of this technique is recommended.

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Perinatal tips

The following case from the files of the Wayne County Medical Society Perinatal Mortality Study Committee is presented as an aid in continuing education.

By Paul M. Zavell, MD
Detroit

Maternal

Little is known of this 21-year-old, Gravida II, Para I, black mother, who had B positive blood. She denied any illnesses during pregnancy other than minor "colds." She had had no known prenatal care. However, at about 37 weeks of gestation she came into the hospital emergency room in labor and quickly delivered a 3 pound 14 ounce baby girl. The mother's postnatal course was uneventful. VDRL in the hospital was negative.

Fetal

The infant had shallow respirations with cyanosis at birth resulting in an Apgar of 6 at one minute and this was still so at five minutes. She was placed in an isolette and 10 percent D/W was started via an umbilical venous catheter. Despite 25 percent environmental O_2 in the isolette respirations continued shallow so that a chest x-ray was done that revealed haziness of the left lower lung. Both penicillin and kanamycin were then started. The cord blood results were now available revealing the baby to be B+. Admission hematocrit was reported as 65 percent. At 12 hours of age the infant was clinically jaundiced with the liver felt 2 cms. below the right costal margin. Bilirubin done at this time was reported as 16 mgm percent so that an exchange transfusion was quickly performed. This went uneventfully. Post exchange bilirubin was 6.5 mgm percent and Hct of 44 percent. At 24 hours of age a purpuric type rash became visible on the abdomen and legs as well as two small areas on the face. X-rays of the skull were negative. X-rays of the long bones showed mottled and demineralized metaphyses with linear and tranverse radiolucent streaks or bands. At 48 hours of age bilirubin was reported as 16.0 (Direct of 10.0)mgm percent. Minimal epistaxis and minimal rectal bleeding were noted at this time on one occasion only. The liver remained at 2 cms below the R.C.M. but the spleen was never palpable. Clear liquid by mouth and eventually Enfamil 24 cal formula were started. Blood studies revealed a Hct of 50 percent, platelet count of 30,000/mm^2, WBC of 8,000, Prothrombin time of 22 (control 12) seconds, PTT of 145 (control 39) seconds and thrombin time of 13.5 (control 3) seconds.

Over the next five days bilirubin remained between 14 and 16 (Direct 8 to 10) mgm percent. At one week of age the stools were noted to be a beige color. By two weeks of age respiratory distress and tachypnea had persisted at a moderate level despite a chest x-ray that now showed the lungs to be clear. However, at this time a heart murmur was heard for the first time. This was diagnosed as a patent ductus arteriosus by a pediatric cardiologist. Because this baby failed to

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Doctor Zavell is chairman, Perinatal Mortality Study Committee, Wayne County Medical Society, and a member of the Neo-Natal and Hospital Care Committee, Michigan Chapter, American Academy of Physicians.

feed well, failed to gain weight and continued with her respiratory distress she was digitalized, given Thiomerin and some whole blood. During hospitalization a transplacental workup on both mother and baby had revealed a negative toxoplasmosis test, negative urine cytomegalic bodies, negative VDRL and FTA and low titers for Coxsackie, echo, polio and herpes viruses. Mother's HAI titers for rubella were 128, 256, 256 and 256 on four successive weeks. The baby's HAI titers for rubella were 256 at two weeks and 2,048 at four weeks. However, cultures of blood and CSF were negative for rubella virus isolation. Despite these efforts continued deterioration in her condition resulted and she expired at 36 days of life from a cardiac arrest.

At autopsy were found a patent ductus arteriosus, hepatitis, ascites and bilateral cataracts. Cultures of heart, brain, liver, spleen, kidney were all negative for rubella virus. the final diagnosis of congenital rubella syndrome was made.

Perinatal Committee Comments

1. Among the findings of congenital rubella are included "blueberry muffin" skin rash, cataracts, signs of congenital heart disease (especially patent ductus), unusual liver functional immaturity, hepatomegaly or hepatosplenomegaly and x-rays of long bones as described earlier. Any of these findings in an infant should alert the pediatrician to this possibility. Use of serial HAI titers in both the mother and the infant can be quite helpful when there is no maternal history of rubella available.
2. Other diagnoses suggested in this case are septicemia, congenital heart disease, Cytomegalic Inclusion Disease and congenital syphilis.
3. A "term" 3 pound 14 ounce infant should alert one to possible problems. The infant could be premature, small for gestational age or be presenting with some metabolic, endocrine, genetic or infected condition (viral, bacterial, etc.). Efforts at arriving at a correct diagnosis should be initiated very soon after birth. Although black infants tend to be smaller at term than white infants, one must not overlook potential problems in any small infant.
4. Although steps to eliminate rubella as a serious problem in pregnancy by immunization of preschool children has been both encouraging and partially successful, problems remain. There is less hazard in the suburbs where most children are currently being immunized and where almost all mothers receive at least some prenatal care. However, frequently inner city hospitals experience numerous "walk-in" pregnancies at term with no known prenatal care and the pregnancies come from among a pediatric population with little or no rubella immunization. The problem is a serious one but rubella in pregnancy can eventually be all but eliminated if all tools available are used. One such is universal rubella testing as a required part of the premarital blood testing program (as syphilis is at present).

National health insurance: Thorns on the rose

By Helen B. Hiscoe, PhD
D. Bonta Hiscoe, MD
East Lansing

Discussions of national health insurance programs tend to concentrate on one of two aspects, depending on one's bias—either satisfaction over the medical benefits they will provide the consumer, or apprehension over the regulation they will exert over the profession. Rarely, if ever, mentioned is the impact of such regulations on the patient. The objectives of the various plans, and the means proposed to achieve them make it obvious that traditional patient freedoms will be curtailed in several areas.

Whichever plan, from Kennedy's to Nixon's, the goal of a national health insurance program is the provision of universally available, high quality medical care at reasonable cost in order to assure better health for all. The public has been led to believe that this can be accomplished by a combination of money and controls applied to the medical establishment. We wish to show how any serious attempt to achieve these goals must inevitably pass on some of these controls to the patient. The planners offer no new magic. Their special proposals for implementation are already being tried in various places to a greater or lesser extent. These measures can be grouped under the categories of preventive medicine, universality of care, promotion of group practice and cost control.

Preventive Medicine

Preventive medicine is a prominent feature of the health care plans because it holds out the promise of economy to the planners and better health to the public.

The most tangible results in preventing disease have come from public health medicine, and probably the most promising avenue to still better health standards is broader and more strict application of its principles. These of course include immunization programs, registration of communicable diseases so that contacts can be followed, treatment of venereal disease, maintenance of sanitation standards and health education. In every case, the individual is expected to comply with regulations for the benefit of all.

However, the sort of preventive medicine conjured up in most people's minds is some program of regular examination which will prevent the occurrence of cancer, heart disease, stroke or diabetes. There is considerable danger that this aspect of the program is being oversold. Success in preventing any of these diseases is very limited at best. The chief benefit to be expected from such examinations would be hopefully earlier diagnosis, but this is least likely for the major killers (e.g., heart disease, cancer and stroke), and more prolonged therapy might well have little impact on the ultimate outcome. Walter McNerney, national director of Blue Cross, has labelled the probable worth of preventive health programs a "myth," and says, "It hasn't been well demonstrated that preventive medicine will keep you healthier."[1]

(Continued)

H. B. Hiscoe, PhD

D. B. Hiscoe, MD

Helen B. Hiscoe, PhD, is associate professor in the Department of Natural Science at Michigan State University. Her husband, D. Bonta Hiscoe, MD, practices general and thoracic surgery and is associate professor of clinical surgery at the MSU College of Human Medicine. He is a past president of the Ingham County Medical Society.

Universality

Clearly the goal of making health care universally available is an essential part of any earnest attempt to improve health standards and provide an equitable distribution of health care. Since there has been no delineation of just what constitutes the level of care which will be considered adequate, the current assumption that everyone should receive all he thinks is necessary has not been denied. As the resources of the country in facilities, manpower and money are unable to meet this demand immediately, the attempt to include everyone will spread the available care more thinly over a larger group. In the process, some who now have all the care they want will probably feel deprived, and some who would rather not participate at all will feel coerced. Meantime, the standard for adequacy of care may of necessity shift from being the need perceived by the patient to the need perceived by the profession. This may also produce some disenchantment.

Specifically, how do planners hope to achieve universality of care?

The first step will probably be a broadening of the public health programs already discussed.

Second may be the sort of screening program already mentioned, for the detection of incipient or early disease. The hope is of course that early diagnosis will make a cure not only possible but economical. The technique in current favor is multi-phasic screening—a highly automated battery of tests periodically given to everyone involved. At present the purpose is to find and bring into the system people who need care. But as more services are offered to more people an already inadequate system may become so overburdened that the purpose will change. This device could and probably would be turned right around to be used as a screening procedure to restrict access to medical care. The Permanente Group, a favorite model of prepaid group practice, makes some use of multi-phasic screening and is beginning to use it to keep patients out as well as bring them in. The screening process identifies the well, worried well, early sick and sick person. Only those with specific medical problems see a doctor. The rest see appropriate paramedical personnel or go home.[2]

Not only will more people be brought into the system, but the system itself will enlarge its jurisdiction by incorporating and integrating many functions now fragmented among social workers, mental health centers, drug and alcohol clinics, family planning and genetic counselling services and others. The medical team is increasingly being charged with behavioral as well as biological responsibility.

Availability of even free medical care does not always guarantee that those who need it will get it. Outreach and home care programs are evolving to ensure that they will.[3] Trained people search out problems in the neighborhood and the home and try to match service and need. Only by giving everyone who can profit by it the health care he needs will health statistics in general be improved. However, it is but a short step from the present paternalistic encouragement of voluntary cooperation to compulsion. Personal experience with a home care team confirms this. Whatever the policy at the top, an overzealous member of the team, dedicated to his or her own modest knowledge, can put undue pressure on a patient. Such a person, for instance, recently denied a woman with terminal cancer her one remaining pleasure by needlessly forcing her to stick to a rigid diabetic diet.

Computers will play an ever greater role as more people are involved, and both the protocol for care and the necessary forms become more standardized. While data banks can prevent duplication of expensive tests and save hours of repetitious history-taking when new doctors enter the case, these records do raise the question of privacy. The more centralized the system the greater the hazards as well as the benefits. At the very least it will mean that the patient cannot run away from his medical past with its clues to his social past as well.

Group Practice

Prepaid group practice (Health Maintenance Organizations or HMOs) have been promoted as the most efficient way to use health manpower and facilities. They would also make it easier to control the professionals in the medical system. Enforcing minimum standards would tend to make the caliber of care more uniform than it is under a system of private practice. Such standards are already being written (in Michigan by the State Health Department) for the handling of certain specific medical problems under Medicare and Medicaid.

Peer review is the mechanism for enforcing these standards. Insurance companies are trying to make peer review work on a voluntary basis. Review mechanisms of Medicare and Medicaid have protected federal money for some time, and now the federal government has put into effect (January, 1973) new legislation for professional standards review organizations. This sweeping plan will try to ensure that providers of services paid by Medicare, Medicaid and Maternal and Child Health Programs offer only medically justifiable services, meet standards for quality care and admit patients only as necessary to the proper level of inpatient institution. It is immediately apparent that these standards include not only what the patient should have but also what he should not have. As the physician is more carefully controlled, this control will inevitably be passed on to the patient. It will be directed not only at the technical aspects of medical practice, but at cost control as well. The current design for *prepaid* group practice (HMOs) makes the physician's profit partly dependent upon his success in minimizing the patient's use of expensive procedures (hospitalization, X-rays, laboratory work, etc.). This of course divides the physician's loyalty between the physical health of his patient and the economic health of his group.

The designers want to give each person what he needs to keep him well or cure him and no more, but sometimes this will seem too little to the recipient. When one is worried and sick, his own picture of the problem is often painted in more dramatic colors than those his doctor chooses. Perhaps the features that would disturb people most about a new system of this type would be the impersonality and delays that usually accompany group or clinic practice. Moreover, if he tends to shop for medical care he might also feel the restriction of choice to the facilities and personnel within the group to which he belongs.

Cost Control

Few would deny that economy of operation must be a primary objective in any national program. Underwriting the entire health bill for the nation, as the Kennedy plan proposes to do, would commit the taxpayer to an outlay of at least 83.4 billion dollars—the total health bill in 1972. And there is little doubt that this would rapidly escalate as the government extended needed services to more people. Regardless of who pays the bill, private agency, government, industry, insurance company or union, costs must be controlled if finite funds are to be distributed equitably and stretched to cover the need.

However, physicians have been trained to disregard cost as an important factor in diagnosis and choice of treatment and to concentrate on curing the patient. Whether pressures toward economy imposed by the HMO concept will succeed in keeping costs down is debatable, since physicians may continue to cater to their patients' wishes for more service. An even more significant obstacle to real economy is the fact that lawyers and juries still judge by present criteria, i.e., that no cost should be spared for the good of the patient, no matter how small the odds that a given procedure will help. Physicians are therefore still motivated to practice defensive medicine, even if it means unnecessary tests and X-rays. If these expensive habits prove difficult to change, they may well result in still more stringent controls.

How will the patient be affected by the measures proposed to bring about this economy? He will be indirectly affected by various actions to make facilities more efficient in the overall scheme and directly affected by the pressures against over-utilization.

When the government passed the Medicare and Medicaid legislation it acknowledged the important role medical facilities play in determining the type of care people get by also passing a bill for comprehensive planning of health facilities (PL89-749, 1966). For example, to prevent duplication of services this bill encourages assigning the various special services to different hospitals within a given area. This would result in a few centers offering comprehensive specialized care of a particular category, each one of higher caliber than would be possible if every hospital tried to cover the entire spectrum of such special services. Of course, the greater the federal contribution to any future plan, the more likely there will be federal control over the provision of medical facilities.

While the patient should benefit from both the efficiency and improved technical quality of care under such an arrangement, he may also find himself somewhat inconvenienced. For instance, while the closing of smaller emergency rooms may well mean that the remaining ones are better equipped to cope with problems, it might also mean a longer trip when speed is vital. Hospitalization farther from home could mean less personal attention. This may also follow the closing of inefficient obstetric units and the restriction of special therapy like cobalt treatment and open heart surgery to fewer hospitals in a larger area.

Certainly the most significant of the measures proposed to promote economy is the control of utilization. For some time Blue Cross, Medicare and Medicaid programs and the Joint Commission on Hospital Accreditation have required that services paid for or approved by them pass the test of utilization review. This puts pressure on the physician to discharge the patient as soon as possible, even though the patient may be reluctant to leave the security of the hospital—his family may resent the burden of his care or they may be unable or unwilling to pay for nursing home care.

Under the present system only the more flagrant cases of over-utilization have been controlled. Since the review committees have consisted of the attending physician's colleagues, coercion has been used reluctantly. Adding to the problem is the fact that physicians usually try to consider their patients' wishes in these matters, since their livelihood at present depends largely on patient goodwill. Finally, the difficult question of where to send the patient frequently has no adequate answer.

This method of peer review will be changed now, under the new federal system of review, at least for all services paid by Medicare, Medicaid and Maternal and Child Health Programs. The committees will be centralized to serve a wide area, and to ensure that those responsible will no longer be the friends and colleagues of the local physician. The responsibility of the PSRO committees

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is already inclusive, involving all institutional care provided. They are to determine whether services and items are medically necessary, whether professional standards of quality are met and whether the service was rendered in an appropriate facility. As soon as possible the plan is to extend this sort of review to non-institutionalized care as well. It is easy to see how comprehensive the control of patient-physician interactions could become if a national health service were established. Again, the greater the role of the federal government, the greater the centralized authority over all these matters and the more rapid the proliferation of forms and detailed regulations.

The effect of the decisions of utilization review committees on the patient varies with the circumstances, but in any case their objective is to see that he gets no more than he needs. Beyond that, however, the decisions carry clues for optimism or despair to the patient and his family. Transfer from the acute care hospital to a chronic care facility implies one thing to the young man recovering from a bad fracture, another to the parents of a child with a brain injury who has not responded to treatment and still another to the patient with advanced cancer.

Cost controls would also affect the allocation of expensive or scarce resources like rare drugs, kidney dialysis, transplants and the prolonged use of life support machinery. Difficult questions already demand answers. Do we accomplish more by immunizing a large number of children or doing one kidney transplant? Should expensive drugs be given to hopelessly incapacitated patients who become acutely ill? Is money spent on heart transplants entirely justifiable.

Concern over costly and dramatic therapy is bound to escalate. Even small services provided to many people can become overwhelmingly expensive. The British have found this true for simple routine Pap smears for the detection of cervical cancer. Cost effectiveness is jeopardizing the continuation of this program.[4]

Conclusions

Any attempt to put all of the facets of the health care problem into perspective must begin with the only generally expressed desire—people want a system which will give everybody whatever medical care he needs and at a price he can afford. Some attempt to satisfy this demand is foreseen in the near future by most observers. What many people have not considered is that even a system successful on the national scale may prove something of a disappointment at the personal level because the individual's definition of satisfactory service may differ quite radically from the definition given by the system. People expect that any acceptable plan will make quality care reasonable and available, but are generally unaware that in practice this will require regulation of their own behavior as well as control of the health professionals.

It may well be that the need is so great that these changes must be accepted as a small price to pay for the results. However, selling the program without acknowledging these probabilities is unrealistic, if not downright hypocritical.

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Polio, measles control target during Immunization Action Month

By Merwyn Scholten
MSMS Department
of Communication

October has been designated national Immunization Action Month by the AMA and other cooperating agencies. The Michigan program will launch a long-range effort to immunize 85 percent of the state's pre-school aged children by October of 1976.

MSMS, the Michigan Department of Public Health, several specialty groups and other health care agencies are participating in the effort to alert the public to the lowering of immunization levels. Only 62.9 percent of the one to four-year-old age group was fully immunized against polio last year according to the 1972 national immunization survey. This is the lowest level of protection in nine years and compares with an 88 percent level in 1964.

"Among the two-year-old children surveyed in four Michigan counties (Kalamazoo, Ottawa, Van Buren and Saginaw) over the past year, four of every 10 children lacked the full recommended polio protection (3 or more OPV)," according to Maurice S. Reizen, MD, Director of MDPH.

Three of every 10 children surveyed were found susceptible to measles and even more were lacking in rubella vaccine. Doctor Reizen noted, "The areas surveyed do not even represent some of the major urban areas where levels tend to be lower."

Measles Cases Total 4,336

At a recent planning meeting co-sponsored by MSMS and MDPH and attended by numerous agencies, pharmaceutical firms and health care groups it was pointed out that Michigan has the "dubious distinction of having the highest reported incidence of measles in the nation this year, 4,336 cases through Aug. 18 compared with 2,353 cases in all of 1972."

Surveys indicate that 50 to 60 of every 100 children in the state begin their immunizations with private physicians. About 30 percent begin with the public health department. "The rest just don't get any immunization service," Doctor Reizen said.

About half of those who begin their immunizations fail to complete them by the end of the second year of life. While the general aim of the effort is to kickoff a vigorous public awareness and educational effort to get all susceptible youngsters properly immunized, a major part of the program is aimed at getting the "immunization dropouts" to complete their series for their own protection.

"It's quite possible that the repeal of the smallpox law coupled with the virtual demise of polio in the state has lulled many parents into assuming that immunizations are no longer necessary," Doctor Reizen suggested.

Publicity Packet

To aid local physicians and component societies, the MSMS Communication Department has sent out a packet of publicity materials to be used with local media. Press releases also have been sent to all media in the state and some news conferences have been held. A poster reminding parents to inquire about their child's immunization status was included as part of the last Medigram.

The MSMS effort is being coordinated by the Committee on Public and Environmental Health and the Committee on Public Relations.

MSMS is especially concerned with reaching the physician and his staff. Since doctors and their assistants represent the best means of reaching patients and parents, physicians are urged to establish contact via phone calls and other means concerning the immunization status of patients," said Louis R. Zako, MD, former chairman of the Committee on Public and Environmental Health.

"MSMS members can do their part individually by reminding parents and patients of the need for immunization against polio, measles, rubella, diphtheria, tetanus and pertussis," concluded Doctor Zako.

Mr. Scholten recently joined the MSMS staff as assistant to Herbert A. Auer, Manager, Department of Communication. Mr. Scholten holds a master's degree in journalism and formerly was public relations director for the Ottawa County Medical Society.

Socio-economic

Report shows geographic distribution of MSMS members by specialty

Physicians practicing family medicine, including geriatrics, make up the largest single specialty group among MSMS members, but by a small margin, according to a newly compiled report from the society's Bureau of Economic Information.

The report, prepared by John Anthony, chief of the bureau, covers 66 specialties assigned to ten groupings and placed geographically by membership in county medical societies. It was compiled as an addition to the MSMS data bank on distribution of physicians for use as an aid for planning to meet health care needs. Mr. Anthony cautioned that natural health care service areas as well as population/physician ratios for a given geographical area must be examined in looking at availability of health care.

"A rural county adjacent to a major metropolitan area is likely to have all services readily available, although a simple statistical analysis of general and physician population in the county itself would not show this," he noted.

The report covers MSMS members only but represents approximately 90 per cent of Michigan's practicing physicians, according to Mr. Anthony.

"We identified physicians as to specialty according to their own designations, as reported to the American Medical Association," he said. "In virtually every case, the physician has had residency training in his or her specialty."

The AMA records were matched with county society membership to set up tables showing geographic distribution.

MSMS Members by Specialty Groupings
Specialty—See Key

COUNTY SOCIETY	1	2	3	4	5	6	7	8	9	10	Total
Alpena-Alcona-Presque Isle	15	1	1	2	2	7	1	1	1	1	32
Alger-Marquette	12	10	3	6	3	17	7	3	4	3	68
Allegan	15	1	1			2	1				20
Baraga-Houghton-Keweenaw	9	1		1	2	5	2	3	2	3	29*
Barry	8			1		2				5	16
Bay-Arenac-Iosco	28	7	5	6	3	21	6	3	8	11	98
Berrien	28	13	8	9	5	23	12	5	7	10	121*
Branch	6	4	3	3	1	6	2	1	1	1	28
Calhoun	32	16	6	8	11	30	11	6	6	14	140
Cass	4	1				2				1	9*
Chippewa-Mackinac	8	3				4	1	2	2		20
Clare-Isabella	9	6	5	3		4	4	1	2	2	36
Clinton	5	1				1				1	9*
Delta-Schoolcraft	16	1		2		3	1	1		1	25
Dickinson-Iron	14	4				6	1	1	1	1	28
Eaton	13	1								2	16
Genesee	88	49	22	27	15	72	15	13	21	48	370
Gogebic	6					2	1				9
Gr. Traverse-Leelanau-Benzie	18	10	1	5	13	14	8	4	4	8	85
Gratiot	13	3	1	1	1	5	1	1	1	3	30

MSMS Members by Specialty Groupings
Specialty—See Key

Hillsdale	10	2		1		2			1		16
Huron	10	2		2		6					20
Ingham	71	45	19	26	21	52	21	14	14	72	355
Ionia-Montcalm	19	2			3	6	1		1	2	34
Jackson	33	18	7	11	4	20	12	4	4	12	125
Kalamazoo	58	43	16	22	20	55	14	7	12	44	292*
Kent	64	70	29	52	23	138	27	17	28	61	509
Lake-Mecosta-Osceola	8	2		1		3				2	16
Lapeer	7			1	2	7	1	2	1	3	24
Lenawee	27	8	1	5	2	8	2	1	2	8	65*
Livingston	10	2				4			1	4	21
Luce	4	1			2					1	8
Macomb	41	43	22	32	5	48	10	6	6	22	239*
Manistee	5	3		1		3		1	1		14
Mason	13			1	1	3		1		3	22
Menominee	3		1		1	1	2	2	1		11
Midland	16	5	2	7	3	11	3	2	3	15	67
Missaukee-Wexford	7	1		2		4	1	1	1	1	18
Monroe	25	6	2	3		7	3		1	7	54
Muskegon	33	18	4	9	7	26	7	6	10	19	140*
Newaygo	6		1								7
North Central	14	2	2			5		1	1	7	32
Northern Michigan	16	16	5	5	1	16	5	4	6	3	77

(Continued)

Key to self-designated specialties in each group

Group 1

- General practice
- General practice w/secondary
- Family practice
- General preventive medicine
- Geriatrics

Group 2

- Cardiovascular disease
- Pediatric cardiology
- Gastroenterology
- Internal medicine
- Diabetes
- Endocrinology
- Hematology
- Infectious diseases
- Neoplastic diseases
- Nephrology
- Nutrition
- Rheumatology
- Pulmonary diseases
- Broncho-esophagology

Group 3

- Pediatrics

Group 4

- Obstetrics and gynecology
- Gynecology
- Obstetrics

Group 5

- Psychiatry
- Child psychiatry
- Hypnosis
- Psychoanalysis
- Psychosomatic medicine

Group 6

- General surgery
- Abdominal surgery
- Cardiovascular surgery
- Colon and rectal surgery
- Hand surgery
- Head and neck surgery
- Neurological surgery
- Orthopedic surgery
- Pediatric surgery
- Plastic surgery
- Thoracic surgery
- Traumatic surgery
- Urological surgery

Group 7

- Ophthalmology
- Otorhinolaryngology
- Laryngology
- Otology
- Rhinology

Group 8

- Pathology
- Clinical pathology
- Forensic pathology

Group 9

- Radiology
- Diagnostic roentgenology
- Nuclear medicine
- Pediatric radiology
- Therapeutic radiology

Group 10

- Allergy
- Pediatric allergy
- Anesthesiology
- Dermatology
- Aerospace medicine
- Legal medicine
- Physical medicine and rehabilitation
- Public health
- Neurology
- Child neurology
- Occupational medicine
- Other specialty
- Unspecified

MSMS Members by Specialty Groupings
Specialty—See Key

Oakland	85	169	73	106	90	159	46	21	40	131	931*
Oceana	6	1								1	8
Ontonagon	6									1	7
Ottawa	30	6	6	6	2	20	5	5	2	13	95
Saginaw	59	19	9	13	8	36	11	8	13	25	203*
St. Clair	18	9	6	10	2	19	7	2	4	6	83
St. Joseph	22					4	1				27
Sanilac	13				1	2			1		17
Shiawassee	9	6	2	3	2	8	2	1		5	38
Tuscola	8		2		1	1				2	14
Van Buren	20					4	2			1	27
Washtenaw	57	64	22	33	72	74	33	20	28	78	486*
Wayne	490	503	132	275	220	538	149	93	143	438	2,986*
TOTAL	1,670	1,198	419	701	549	1,516	439	264	385	1,102	8,277*

*These figures include from one to eleven members who did not indicate their specialty.

MSMS Bureau offers reprints of articles

The MSMS Bureau of Economic Information is once again making available copies of articles and publications for which it has been responsible over the past two years. To obtain any or all of the titles listed below, please check those you want and fill in your name and address at the bottom of the page. If you are ordering copies of the Michigan Relative Value Study, please enclose a check for $3 for each copy. Allow two-to-three weeks for delivery.

____"MSMS Economic Bureau Releases Survey Information re Insurance, Suits"

____"Latest MSMS Survey Shows Physicians' Costs Still Rising"

____"MSMS Survey Finds 92.7 percent of Primary Care MDs Surveyed are Accepting New Patients"

____"Children's Deaths in Michigan"

____"Where do Michigan Physicians Come From?"

____"How Physicians are Affected by Price Stabilization Regulations"

____"Just a Few Component Societies Have Most MSMS Members"

____"Here are the Facts on Physicians' Fees by Area & Procedure" (1971 Fee Survey)

____"Explains Methods Used to Determine Medicare and Medicaid Percentiles"

____"The Source of Health Care Problems of the Urban Poor"

____"Here's Ratio of Physicians/Patients in 10 Biggest States"

____"The Decline of the U.S. Birth Rate"

____"Physician's Charges Must Rise to Meet His Costs"

(There is no charge for any of the articles listed above.)

____1971-1972 Michigan Relative Value Study, $3 per copy

____1973 Michigan Relative Value Study (matched codes), $3 per copy

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Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (> 5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. **Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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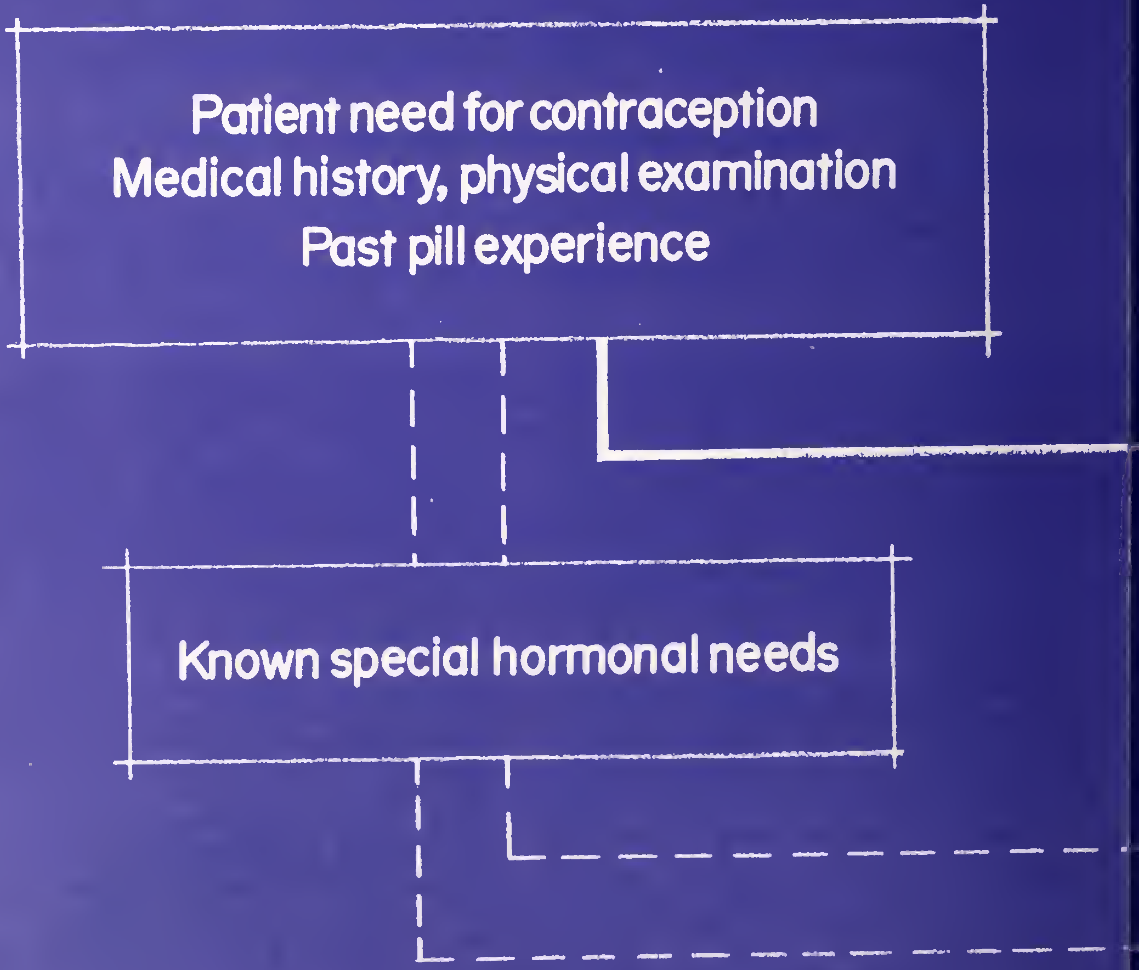

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Where "The Pill" Began

primarily on animal studies.

Note: Oral contraceptives are complex medications. As with all medications they should be prescribed with discriminating care, and only after reference to full prescribing information. For brief summary of prescribing information, please see next page.

If one "pill" were right for every woman, we'd make it.

Ovulen® **Available in 20-, 21- and 28-pill schedules**

Each white tablet contains: ethynodiol diacetate 1 mg./mestranol 0.1 mg.

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Demulen® **Available in 21- and 28-pill schedules**

Each white tablet contains: ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg.

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Actions—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in the United States. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 1967. **2.** Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. *2*:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. *2*:651-657 (June 14) 1969. **4.** Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem *90*:365-380 (Nov.) 1969.

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Indication—Enovid-E is indicated for oral contraception.

The *Special Note*, *Contraindications*, *Warnings*, *Precautions* an *Adverse Reactions* listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E

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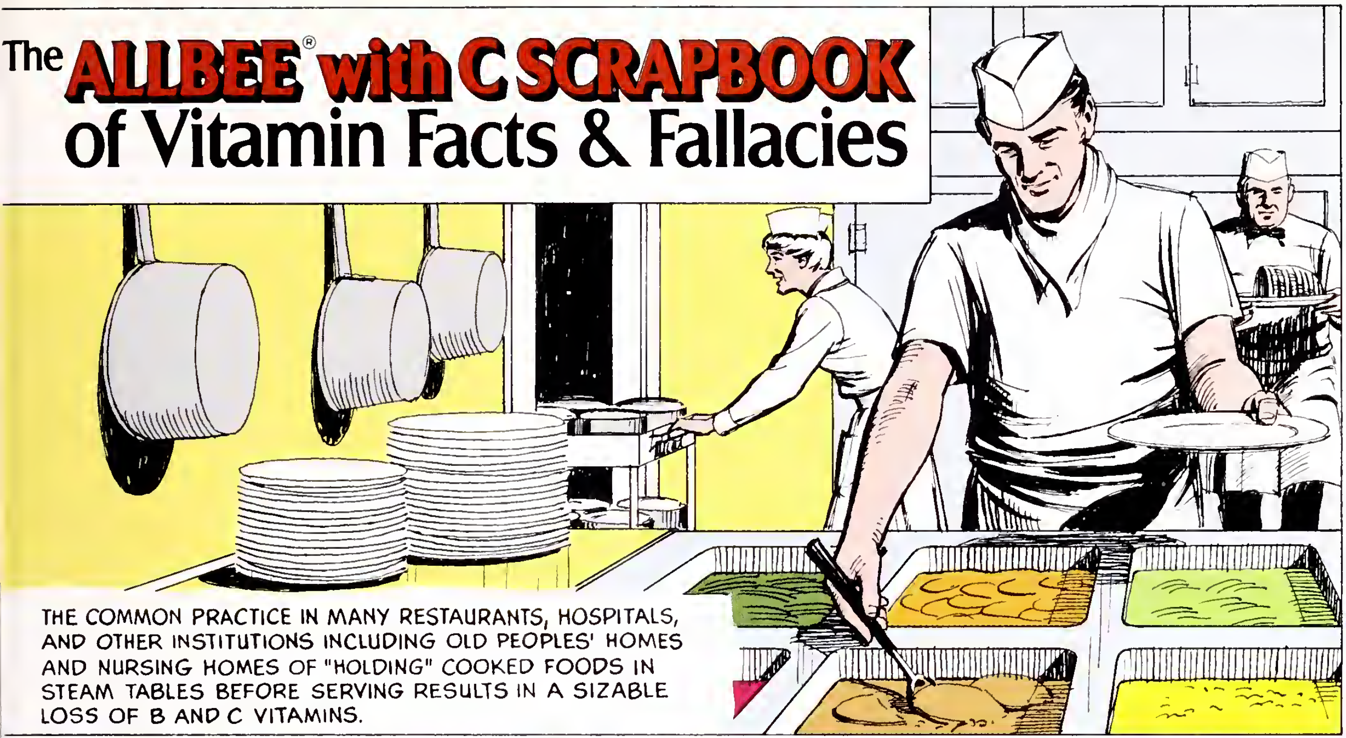

THE COMMON PRACTICE IN MANY RESTAURANTS, HOSPITALS, AND OTHER INSTITUTIONS INCLUDING OLD PEOPLES' HOMES AND NURSING HOMES OF "HOLDING" COOKED FOODS IN STEAM TABLES BEFORE SERVING RESULTS IN A SIZABLE LOSS OF B AND C VITAMINS.

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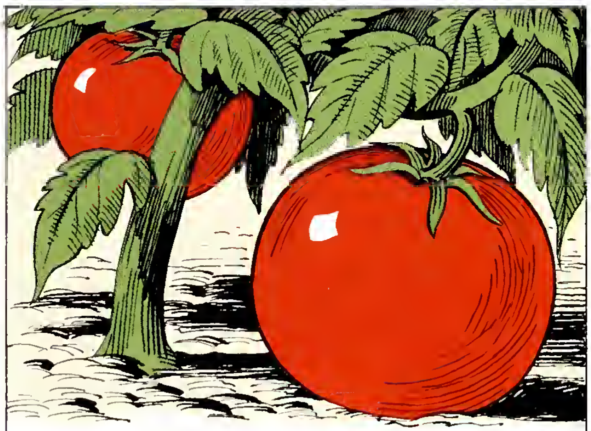
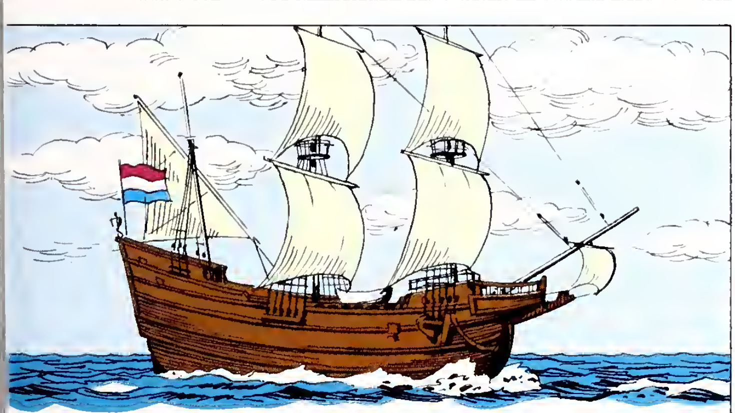


THE AMOUNT OF SUNLIGHT AVAILABLE DURING RIPENING DETERMINES TO A LARGE EXTENT THE FINAL ASCORBIC ACID CONTENT OF TOMATOES. HENCE, A COOL, WET SUMMER PRODUCES WATERY, LESS TASTY FRUIT THAT'S LOWER IN VITAMIN C.



RONSSENS, A DUTCH PHYSICIAN, WROTE IN 1564 THAT "DUTCH SAILORS WHO, RETURNING FROM SPAIN, WERE ATTRACTED BY THE NOVEL RICHNESS OF THE FRUIT (ORANGES) AND BY THEIR GREED AND GLUTTONY, UNEXPECTEDLY DROVE OUT THE DISEASE (SCURVY), AND HAD THIS HAPPY EXPERIENCE NOT ON A SINGLE OCCASION ONLY, BUT REPEATEDLY."

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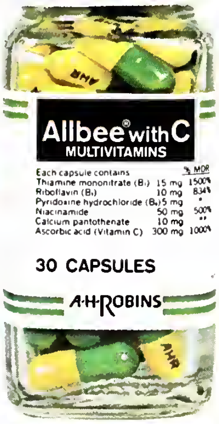
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phenobarbital (warning: may be habit forming)	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.

Brief summary. Adverse Reactions: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Contraindications: Glaucoma; renal or hepatic disease; obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); or hypersensitivity to any of the ingredients.

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AMA Legislative Department provides many services to member physicians

By James Imboden
AMA Field Service Representative
Michigan, Ohio, Virginia, West Virginia

The AMA Legislative Department provides a vital service to member physicians all across the country. At the same time, it is regarded by many as one of the most substantial of the intangible benefits which the AMA offers to its membership.

The Legislative Department staffs the AMA Council on Legislation and specializes in all phases of national legislation. After studying, analyzing, and interpreting all Congressional legislation pertaining to medical and health care, the department makes available this information to state, county, and specialty medical societies, members of the public, and other organizations. This usually totals about 2,300 bills of medical interest per Congress.

An increased responsibility of this department is the critical review of government regulations which often seriously affect application of law. There are few physicians who could devote the time necessary to accomplish this on their own and, yet, this information is vital because it affects the way medicine is practiced in this country.

To keep key medical leadership aware of legislative developments when Congress is in session, the department writes, publishes, and distributes *Legislative Round-up*, weekly, to approximately 5,000 key state, county, and specialty medical society officers.

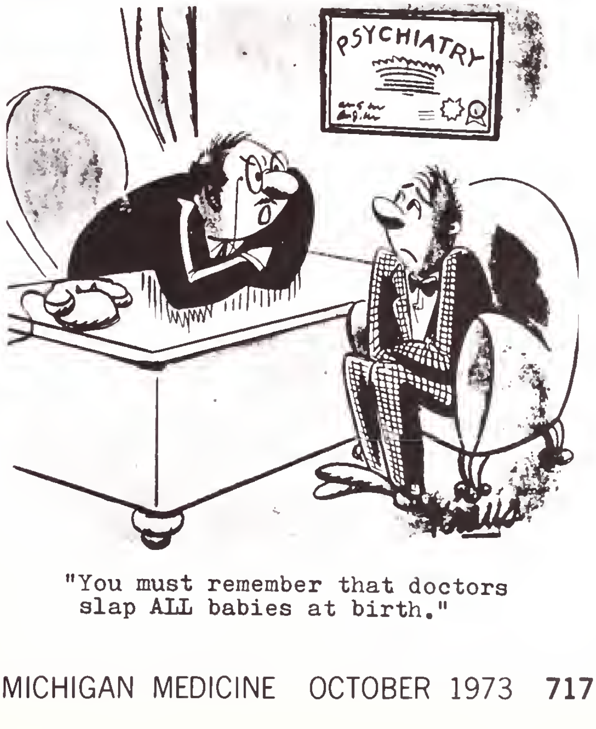
Another vital activity is the assistance given to AMA officers in the preparation of testimony and presentations for Congressional hearings. The Legislative Department works with the appropriate AMA scientific personnel to gain the benefit of their expertise before assembling any presentation. The Council on Legislation can then use this resource material to formulate a sound recommendation as to the best policy position for the AMA. Many people do not realize the AMA is often requested to testify because its views are valued not only by Congress but by the various governmental agencies.

The department also assists in the development, writing, and presentation of draft legislation for consideration by members of Congress, such as the AMA's own national health insurance bill, Medicredit. They also assist in the development of presentations to the regulatory agencies.

The staff participates in providing legislative orientation to the AMA's Councils and Committees as well as to members of the profession who are in Washington, D. C. to visit members of Congress.

Finally, the department has undertaken the monitoring of state legislation with a view towards eventually assisting the profession to attain its legislative goals on a state as well as on a national level.

From Medicaid and Medicare regulations to chiropractic issues, national health insurance and appropriations for HEW programs, federal and state medical and health care legislation affects all physicians in some way. The AMA's Legislative Department maintains constant surveillance and provides AMA physician policy makers with accurate and up-to-date information. The leadership of organized medicine can make their judgments and represent AMA's membership with a sound base of resources.



"You must remember that doctors slap ALL babies at birth."

Recommendations[†] on Combination Live Virus Vaccines

American Academy of Pediatrics

Committee on Infectious Diseases

In the September 15, 1971 *AAP Newsletter* sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."

United States Public Health Service

Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidity and Mortality Weekly Report,* the Advisory Committee on Immunization Practices of the United States Public Health Service presented recommendations on the use of combination live virus vaccines. The committee stated that:

- "Data indicate that antibody response to each component of these combination vaccines is comparable with antibody response to the individual vaccines given separately.
- "There is no evidence that adverse reactions to the combined products occur more frequently or are more severe than known reactions to the individual vaccines (see pertinent ACIP recommendations).
- "The obvious convenience of giving already selected antigens in combined form should encourage consideration of using these products when appropriate."

[†] For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.

M-M-R*

(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials

M-M-R, given in a single injection, fits easily into your routine immunization program for well babies.

Given at age 12 months, M-M-R provides for vaccination early in life against measles, mumps, and rubella.

MSD suggested immunization schedule for well babies

Age	Vaccine(s)
2 months	DPT (diphtheria-pertussis-tetanus) Oral poliomyelitis vaccine (triple)
3 months	DPT[1]
4 months	DPT Oral poliomyelitis vaccine (triple)
6 months	Oral poliomyelitis vaccine (triple)
12 MONTHS	**M-M-R (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE, MSD)**

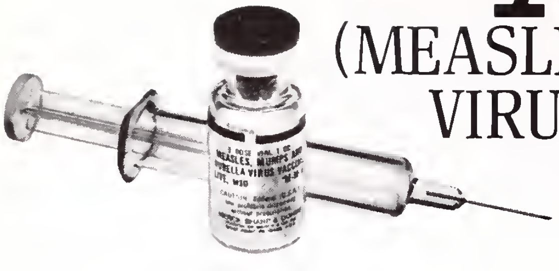
[1] This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.

Since vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and the vaccine should not be given during the same office visit.

*Trademark of Merck & Co., Inc.

For a brief summary of prescribing information, please see following page.

M-M-R



(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials

No untoward reactions peculiar to the combination vaccine (M-M-R) have been reported.

Moderate fever (101-102.9 F) occurs occasionally. High fever (over 103 F) occurs less commonly. On rare occasions, children who develop fever may exhibit febrile convulsions. Rash (usually minimal and without generalized distribution) may occur infrequently.

Since clinical experience with measles, mumps, and rubella virus vaccines given individually indicates that very rarely encephalitis and other nervous system reactions have occurred, such reactions may also occur with M-M-R. A cause and effect relationship, however, has not been established.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Must not be given to women who are pregnant or who might become pregnant within three months following vaccination.

Contraindications: Pregnancy or possibility of pregnancy within three months following vaccination; infants less than one year old; sensitivity to chicken or duck, chicken or duck eggs or feathers, or neomycin; any febrile respiratory illness or other active febrile infection; active untreated tuberculosis; therapy with ACTH, corticosteroids, irradiation, alkylating agents, or antimetabolites; blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems; gamma globulin deficiency, i.e., agammaglobulinemia, hypogammaglobulinemia, and dysgammaglobulinemia.

Precautions: Administer subcutaneously; do not give intravenously. Epinephrine should be available for immediate use should an anaphylactoid reaction occur. Should not be given less than one month before or after immunization with other *live* virus vaccines; vaccination should be deferred for at least six weeks following blood transfusions or administration of more than 0.02 cc immune serum globulin (human) per pound of body weight, or human plasma.

Due caution should be employed in children with a history of febrile convulsions, cerebral injury, or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur after vaccination.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Attenuated live virus measles and mumps vaccines, given separately, may temporarily depress tuberculin skin sensitivity; therefore, if a tuberculin test is to be done, it should be scheduled before vaccination, to avoid the possibility of a false negative response.

Before reconstitution, refrigerate vaccine at 2–8 C (35.6–46.4 F) and *protect from light.* Use only diluent supplied to reconstitute vaccine. If not used immediately, return reconstituted vaccine to refrigerator at 2–8 C (35.6–46.4 F), and discard after eight hours.

Adverse Reactions: Fever, rash; mild local reactions such as erythema, induration, tenderness, regional lymphadenopathy; parotitis; thrombocytopenia and purpura; allergic reactions such as urticaria; arthritis, arthralgia, and polyneuritis.

Occasionally, moderate fever (101–102.9 F); less commonly, high fever (above 103 F); rarely, febrile convulsions.

Encephalitis and other nervous system reactions that have occurred very rarely with the individual vaccines may also occur with the combined vaccine.

Transient arthritis, arthralgia, and polyneuritis are features of natural rubella and vary in frequency and severity with age and sex, being greatest in adult females and least in prepubertal children. Such reactions have been reported with live attenuated rubella virus vaccines. Symptoms relating to joints (pain, swelling, stiffness, etc.) and to peripheral nerves (pain, numbness, tingling, etc.) occurring within approximately two months after immunization should be considered as possibly vaccine related. Symptoms have generally been mild and of no more than three days' duration. The incidence in prepubertal children would appear to be less than 1% for reactions that would interfere with normal activity or necessitate medical attention.

How Supplied: Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 $TCID_{50}$ (tissue culture infectious doses) of measles virus vaccine, live, attenuated, 5,000 $TCID_{50}$ of mumps virus vaccine, live, and 1,000 $TCID_{50}$ of rubella virus vaccine, live, expressed in terms of the assigned titer of the NIH Reference Measles, Mumps, and Rubella Viruses, and approximately 25 mcg neomycin, with a disposable syringe containing diluent and fitted with a 25-gauge, 5/8" needle. Also in boxes of 10 single-dose vials nested in a pop-out tray with a separate box of 10 diluent-containing syringes.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

MSD
MERCK
SHARP&
DOHME

MSMS action

Call Medical Memo for news, answers to questions

"Thank you, Doctor, for calling Medical Memo. You now may record a message for the MSMS staff."

This invitation, which closes every news report recorded for the state medical society's new electronic communications system, frequently can mean a fast answer to a puzzling question.

Initially, the MSMS Communication Department planned Medical Memo as a news reporting service, permitting members to call toll-free from throughout Michigan for a recorded message. However, expansion of the service to include two-way communication makes it possible for the society's headquarters staff to provide two new services to members.

The news message is changed weekly, on Mondays, except when new reports are added as spot news breaks. The service is in opertion 24 hours a day, seven days a week, and this means that a physician may call at his own convenience.

MSMS staff endeavors to answer each question recorded by a physician within 24 hours. Answers that must be researched sometimes take longer. Callers also may request printed materials, including brochures about travel programs and MSMS member benefits, and express opinions on matters which are before society committees or governing bodies.

Following is a sampling of general interest questions, with answers, handled by Medical Memo since its debut in May.

Medical Memo, the new MSMS toll free telephone message service, provides both a short taped news message and time to leave a question for MSMS staff to answer. Phone anytime.

1-800-292-1460

Or if you are served by General Telephone, dial 120-800-292-1460.

Question: What medicines under law have to be put in baby proof bottles?

Answer: Action by Congress in 1970 gave the Federal Drug Administration authority which resulted in regulations requiring safety containers for all prescription drugs and 4,300 over-the-counter products, including all aspirin products. Some specific exemptions were made on the basis of quantities. The aspirin regulation was effective Aug. 25, 1972, and rules applying to "all substances considered potentially hazardous to children" on Oct. 24, 1972. The Michigan legislature is considering a proposed law that would extend coverage to products manufactured and marketed only in Michigan and packaged in drug stores with authority for enforcement given to the State Board of Pharmacy.

Question: How can I secure free laboratory supplies for gonorrhea testing offered by the Michigan Department of Public Health?

Answer: Contact your county or city public health department or MDPH laboratories. Laboratory supplies and services utilizing Transgrow or Thayer-Martin media for gonorrhea testing are available throughout the state. Mail service to and from the Bureau of Laboratories, Michigan Department of Public Health, Lansing, Mich. 48906, is available in counties with low incidence of gonorrhea. Local service is available in high incidence counties.

Question: Is there any legal reason why Blue Shield or other third party payer can refuse to accept the assignment of a patient to pay a doctor directly?

Answer: Blue Shield officials report that it follows a state administrative ruling forbidding insurance carriers to accept patients' assignments of partial payments for health care services to physicians. Such payments may be made directly to physicians only when the amount represents payment in full. In the case of Blue Shield, this would be payments to participating physicians. The regulations in effect today are based on a consent decree issued by the Michigan insurance commissioner in 1963. Prior to that time, Blue Shield made both partial and full payments to physicians.

(Continued)

Medico-legal

The AMA's Citation *newsletter, prepared by the AMA Law Department, lists the following cases involving health personnel in Michigan. Persons interested in obtaining more information on individual cases may write MSMS headquarters.*

"Doctors' offices
in tax-exempt hospital not taxable"
Michigan Court of Appeals, Oct. 26, 1972
from *The Citation,* Vol. 27, No. 6

"Malpractice does not apply
to negligence by nurse"
Michigan Supreme Court, March 27, 1973
from *The Citation,* Vol. 27, No. 6

MEDICAL MEMO/Continued

Question: Where can I get information on proper authorization for autopsies?

Answer: ***Medicolegal Forms,*** printed by the Office of the General Counsel of the American Medical Association, contains a series of suggested forms for use by physicians, hospitals and attorneys. The 1973 revised edition contains a discussion of recent court decisions and legal analysis. It gives emphasis to consent and informed consent and contains a new section on transplantation. The book is available from the Office of General Counsel, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610. The AMA recommends that because state laws vary physicians and hospitals consult their own attorneys before using the suggested forms.

Question: Has the new rule concerning physician attendance at blood banks gone into effect?

Answer: Extensive new rules governing blood banks were issued by the Department of Public Health and took effect June 15 of this year. The new rules permit blood banks to submit to the department a plan for physician coverage of the blood bank other than physical presence. The department must approve of the alternate plan. The department says it is implementing the new rules now and will initiate contact with blood banks individually within the year.

Physicians have used Medical Memo for a large number of specific requests. Names of legislators representing a specific area, the address of the Texas Medical Association, health education brochures and legal advice from the MSMS counsel on release of patient records are among requested items.

The service is continuing on a trial basis and will become permanent if found to be valuable to MSMS members.

Dear Doctor:

This month's "Bio-Science Reports," on the page opposite, is another service of Bio-Science Laboratories.

From time to time, you'll be seeing different reports in Michigan Medicine dealing with laboratory medicine as it applies to your clinical practice.

Over the past 25 years, physicians such as yourself have found that our laboratory service provides a continuing source of accurate results and helpful literature.

Please use the coupon at the bottom of the "Bio-Science Reports" to request any information about our services, fees, or free starter materials.

We are looking forward to serving you.

Sincerely,

Donald C. Cannon

Donald C. Cannon, M.D., Ph.D.
Director

25 YEARS
Bio-Science
Laboratories

Bio-Science Reports

Serum Parathyroid Hormone as a Diagnostic Aid

An accurate measurement of the serum level of parathyroid hormone (PTH) with results reported from the laboratory within about ten days is now available. The diagnosis of diseases of the parathyroid has always been a difficult, serious problem and we now have a powerful laboratory tool which will help solve some of the diagnostic dilemmas and further stimulate research in this field.

The classic laboratory findings in primary hyperparathyroidism are, of course, high serum calcium and low serum phosphorus; high urinary calcium is also commonly found. Increased phosphate excretion due to inhibition of phosphate reabsorption (TRP) and measurement of the TRP are additional laboratory aids for diagnosing hyperparathyroidism. All of these tests are obviously indirect procedures for establishing the diagnosis so there is a distinct value in having a direct measure of PTH.

In spite of the complexity and difficulty of the radioimmunoassay technic for PTH, it is now possible to quantitate the hormone with reasonable precision and in most cases to differentiate normal from hyperparathyroid serum levels. Human PTH is not available in sufficient quantities to use as an antigen or standard, but guinea pig antiserum to bovine PTH has sufficient cross-reactivity with human PTH to allow its effective use in the assay.

Unfortunately, the lack of a human parathyroid standard complicates any comparison of results from different laboratories. At Bio-Science a purified bovine PTH preparation is used as the standard and results are expressed as equivalents of purified bovine PTH. The antiserum used gives similar curves with both human serum PTH and purified bovine PTH and does not distinguish between the two.

The specimen requirement for the PTH assay is: 5 ml. frozen serum obtained from blood which has been drawn between 6 and 9 a.m. while the patient is in the rested, fasting state. The blood should be drawn with a chilled syringe or Vacutainer and kept in an ice bath until the serum can be separated, preferably in a refrigerated centrifuge. Separation of the serum from the cells and freezing should be completed as soon as possible. The frozen serum should be sent to us packed in dry-ice. Shipping containers intended for frozen specimen shipments are available without charge.

Write or call, collect, for additional literature on this subject and containers for mailing.

25 YEARS

Main Lab: 7600 Tyrone Ave.,
Van Nuys, California 91405
Philadelphia Branch:
116 So. Eighteenth St.,
Philadelphia, Pa. 19103

Bio-Science Laboratories
7600 Tyrone Avenue
Van Nuys, California 91405 Dept. W
or
116 So. Eighteenth St.
Philadelphia, Pa. 19103

Gentlemen: Please send me, without obligation:

☐ A copy of your Handbook of Specialized Diagnostic Laboratory Tests

☐ A lab pack containing a small supply of postage-paid mailing containers and Fee Schedule

☐ Information on ______________________
(write in name of test)

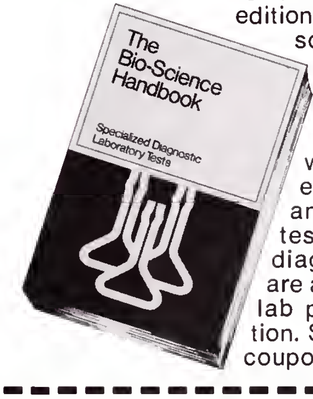
Name ______________________

Address ______________________

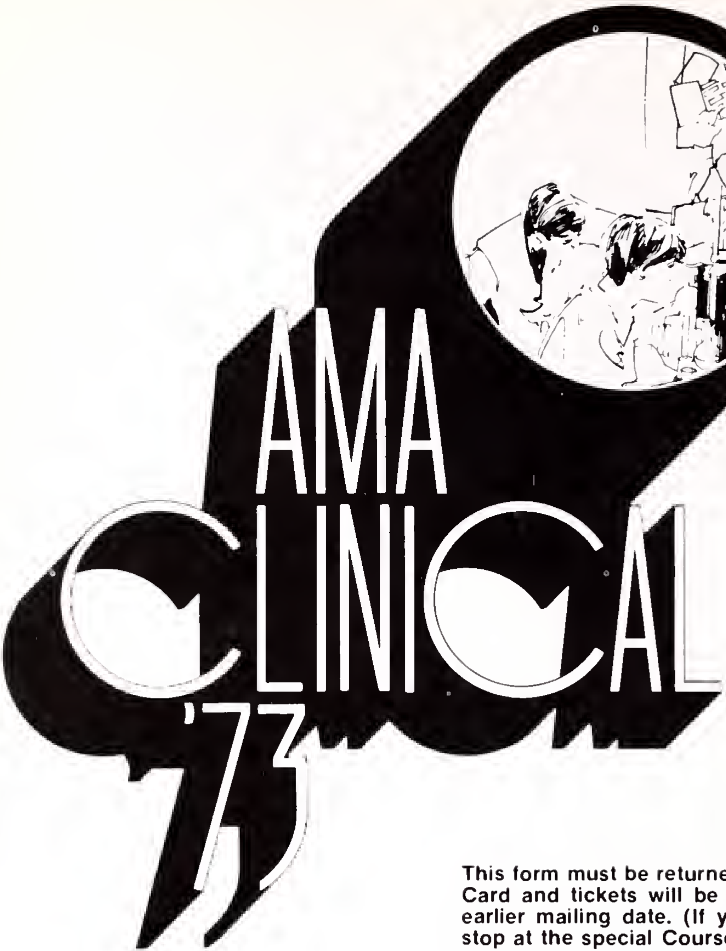
City ____________ State ____________ Zip ____________

FREE

HANDBOOK OF SPECIALIZED DIAGNOSTIC LABORATORY TESTS



This 200-page book, now in its tenth edition, is a uniquely informative source to keep you up-to-date on the newer laboratory tests, such as parathyroid hormone, available to clinicians. You will find it a handy reference guide for normal values and quick summations on tests which can aid in your diagnostic problems. Copies are available to physicians and lab personnel without obligation. Simply fill out and mail this coupon.



New Dimensions in Continuing Education Anaheim, Cal. December 1-4

It's the practicing physician's clinic for continuing education...offering a uniquely personalized educational experience: 30 postgraduate courses covering new treatments and techniques in most major specialties. With 6 scientific sessions, film symposia, scientific and industrial exhibits...all designed to help provide new solutions to those everyday health-care problems. Plus a conference on the current status of Professional Standards Review Organizations. Altogether, AMA Clinical '73 promises to be the practicing physician's prescription for better patient care.

This form must be returned before November 5, 1973. Your Advance Registration Card and tickets will be sent to you on November 12, unless you request an earlier mailing date. (If you do not receive your Postgraduate Course Tickets, stop at the special Course Registration Desk at the Anaheim Convention Center. If the course(s) of your choice has been filled, your check will be returned immediately after the convention.)

Advance Registration

Please return to:
Circulation and Records Department
American Medical Association
535 North Dearborn Street/Chicago, Illinois 60610

General Registration

- ___ AMA members and their guests: no fee
- ___ Non-member physicians: $25
- ___ Guests of non-members: $5
- ___ Medical students, interns and residents: no fee
- ___ I am a member of the AMA through the ____________ State Medical Association or in the following government service ________________

Postgraduate Course Registration

Registration fee.* $25/4½ hr. course
$40/9 hr. course

*All medical students, interns and residents:
$12.50/4½ hr. course
$20/9 hr. course

All courses meet Sunday, Monday, Tuesday/Dec. 2-4. Please indicate 1st, 2nd and 3rd choice for each time. (Minimum course registration is 25 physicians. If this number is not attained, your 2nd or 3rd choice will be substituted.)

7:30-9:00 a.m. (4½ hr. course)

- ___ Asthma-Causes, Pathogenesis, Treatment
- ___ Diagnostic Ultrasound
- ___ Efficient Task Allocation in Medical Practice
- ___ Four Million Epileptics-Outlook 1974
- ___ Heart Sounds and Their Interpretation
- ___ Impact of Welfare Policies on the Delivery of Health Care
- ___ Industrial Medicine in the Small Manufacturing Plant
- ___ Tumors of the Breast

9:30 a.m.-12:30 p.m. (9 hr. course) S

- ___ Advanced Electrocardiography
- ___ Appraisal of New Pulmonary Diagnostic Techniques
- ___ Coronary Risk Factors
- ___ Epidemiology and Management of the Acutely Injured Patient
- ___ Factors Affecting Fetal Development and Neonatal Adaptation
- ___ High-Risk Obstetrics and Fetal Monitoring
- ___ Immunology 1974
- ___ Infectious Diseases
- ___ New Clinical Practice from the Basic Sciences
- ___ Pulmonary Function and Blood Gases-Assessment and Diagnosis
- ___ Vascular Disease of the Head and Neck

2:00-5:00 p.m. (9 hr. course)

- ___ The Anatomy of Surgical Procedures
- ___ Basic Electrocardiography
- ___ Clinical Impact of Recent Alcoholism Research
- ___ Critical Patients-Critical Decisions
- ___ Diagnostic Cardiology
- ___ Liver Diseases
- ___ Managing the Diabetic in Trouble
- ___ Office Evaluation of Cervical Lesions
- ___ Problems in Child Development
- ___ Salt, Water and Acid Balance and Imbalance
- ___ Vascular Surgery

My remittance of $________ is enclosed.
(Make check payable to American Medical Association.)
Check must accompany registration.

Please print
Name ________________________________
(each physician must register in his own name)
Office Address ________________________________
City/State/Zip ________________________________

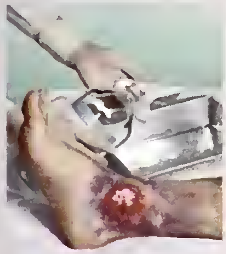
adjunctive therapy for wound debridement

HELPS TO REMOVE:

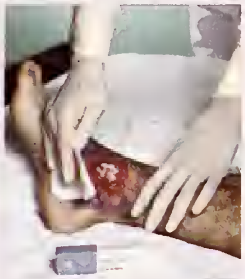
- Necrotic Tissue and Associated Odor

HELPS PREPARE WOUND FOR:

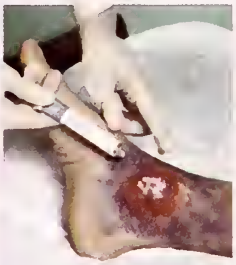
- Granulation/Healing
- Granulation/Grafting



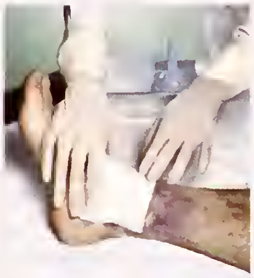
CLEANSE WOUND
Thoroughly cleanse and irrigate wound area with sodium chloride or water solutions. Wound MUST be cleansed of antiseptics or heavy-metal antibacterials.



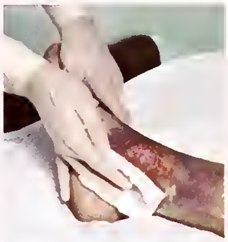
THOROUGHLY MOISTEN
Thoroughly moisten wound area either through tubbing, showering, or wet soaks (e.g., sodium chloride or water solutions).



APPLY ENZYME
Apply a layer of TRAVASE Ointment. Assure intimate contact with necrotic tissue and complete wound coverage.



APPLY MOIST DRESSING
Apply loose moist dressings (most important with dry leathery eschar).



CHANGE DRESSINGS
When changing dressing, gently wipe away the dissolved material. Repeat the procedure, including application of TRAVASE Ointment, 3 to 4 times per day for best results.

Travase® Ointment

brand of Sutilains

Travase® Ointment
brand of Sutilains
FLINT
REFRIGERATE

Travase® Ointment
brand of Sutilains

Indications
For wound debridement (1,2)—TRAVASE Ointment is indicated as an adjunct to established methods of wound care for biochemical debridement of the following lesions:

Second and third degree burns.
Decubitus ulcers.
Incisional, traumatic, and pyogenic wounds.
Ulcers secondary to peripheral vascular disease.

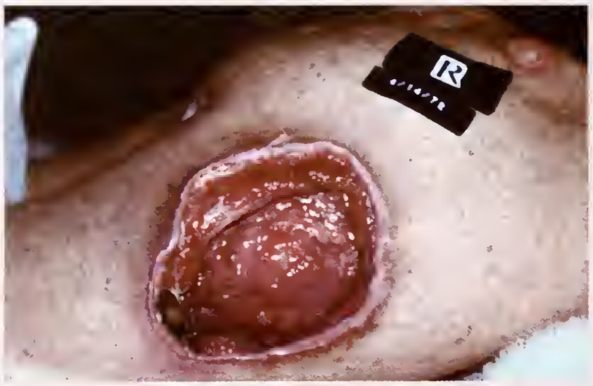
FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC
Deerfield, Illinois 60015

Please see next page for prescribing information.

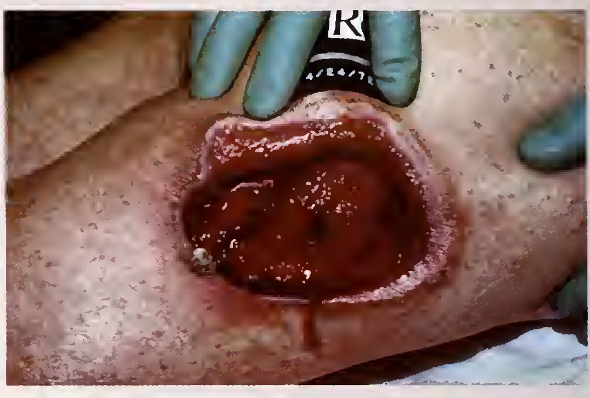
Travase® Ointment brand of Sutilains

ulcers

TERRY V. CARLE, M.D., CLINICAL INSTRUCTOR, DEPT. OF PHYS. MED. & REHAB.,
CRAIG REHABILITATION HOSPITAL, UNIVERSITY OF COLORADO



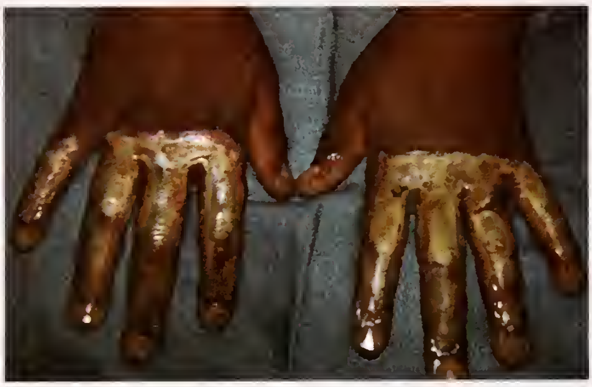
Before treatment, necrotic matter coated the inner surfaces of this decubitus ulcer.



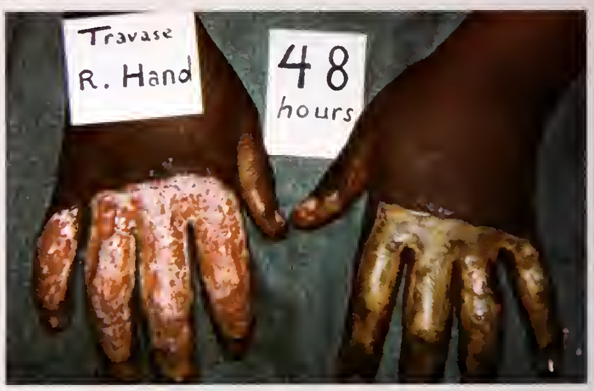
After nine days of TRAVASE therapy, debridement is nearly complete and granulation evident.

burns

DALE B. DUBIN, M.D., DIPLOMATE,
AMERICAN BOARD OF PLASTIC SURGERY, TAMPA, FLORIDA



Before treatment . . .



48 hours following treatment with TRAVASE Ointment on right hand; left hand is control.

Travase® Ointment

(brand of Sutilains)

Indications: For wound debridement, TRAVASE Ointment is indicated as an adjunct to established methods of wound care for biochemical debridement of the following lesions:

Second and third degree burns,
Decubitus ulcers,
Incisional, traumatic, and pyogenic wounds,
Ulcers secondary to peripheral vascular disease.

Contraindications: Application of TRAVASE Ointment is contraindicated in the following conditions:

Wounds communicating with major body cavities,
Wounds containing exposed major nerves or nervous tissue,
Fungating neoplastic ulcers,
Wounds in women of child-bearing potential—because of lack of laboratory evidence of effects of TRAVASE upon the developing fetus.

Warning: Do not permit TRAVASE Ointment to come into contact with the eyes. If contact is made, immediately rinse with copious amounts of water, preferably sterile.

Precautions: A moist environment is essential to optimal activity of the enzyme. Enzyme activity may also be impaired by certain agents (see package insert). Although there have been no reports of systemic allergic reaction in humans, studies have shown that there may be an antibody response in humans to absorbed enzyme material.

Adverse Reactions: Consist of mild, transient pain, paresthesias, bleeding and transient dermatitis. Pain usually can be controlled by administration of mild analgesics. Side effects severe enough to warrant discontinuation of therapy occasionally have occurred.

If bleeding or dermatitis occurs as a result of the application of TRAVASE Ointment, therapy should be discontinued. No systemic toxicity has been observed as a result of the topical application of TRAVASE Ointment.

DOSAGE AND ADMINISTRATION: STRICT ADHERENCE TO THE FOLLOWING IS REQUIRED FOR EFFECTIVE RESULTS OF TREATMENT:

1. Thoroughly cleanse and irrigate wound area with sodium chloride or water solutions. Wound MUST be cleansed of antiseptics or heavy-metal antibacterials which may denature enzyme or alter substrate characteristics (e.g., hexachlorophene, silver nitrate, benzalkonium chloride, nitrofurazone, etc.).
2. Thoroughly moisten wound area either through tubbing, showering, or wet soaks (e.g. sodium chloride or water solutions).
3. Apply TRAVASE Ointment in a thin layer assuring intimate contact with necrotic tissue and complete wound coverage extending ¼ to ½ inch beyond the area to be debrided.
4. Apply loose wet dressings.
5. Repeat entire procedure 3 to 4 times per day for best results.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC
Deerfield, Illinois 60015

Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

George N. Austin, MD, 920 Townsend St., Lansing, 48933
Orhan Baybura, MD, 503 E. Main St., Edmore, 48829
James M. Bullock, MD, 4528 S. Hagadorn Rd., East Lansing, 48823
Keith C. Burnes, MD, 235 Warwick Drive, Alma, 48801
Charles R. Henry, MD, 515 Lakeside Dr., S. E., Grand Rapids, 49506
Zafar Iqbal, MD, 479 Lafayette, Ionia, 48846
Dennis Marion, MD, 2909 E. Grand River, Lansing 48912
H. James McCoy, MD, 2909 E. Grand River, Lansing, 48912
Roger D. Miller, MD, 21 Michigan St., N. E., Grand Rapids, 49502
Joseph T. Oettinger, MD, 2110 Enterprise, S. E., Grand Rapids, 49508
Roger W. Pietras, MD, 425 Cherry St., S.E., Grand Rapids, 49503
Charles W. Roelofs, MD, 227 College Ave., S. E., Grand Rapids, 49503
Inkun Shin, MD, 3446 Northway Ct., Bay City, 48706
Raul R. Verde, MD, 833 Lake Drive, S.E., Grand Rapids, 49506
H. Jay Zeskind, MD, 1711 A-Gardenia #5, Royal Oak, 48067

Ohio doctor lists drugs for athletes to avoid

A list of drugs *not* recommended for use by athletes was reviewed at the Eighth Annual MSMS Conference on the *Medical Aspects of Michigan High School Sports* held recently in Lansing by Robert J. Murphy, MD, team doctor for the Ohio State Buckeyes.

He suggested the following *not* be prescribed:

1. Local anesthetics
2. Narcotics
3. Tranquilizers
4. Alcohol
5. Vasodilators
6. DSMO solvent
7. Amphetamines
8. Anabolic steroids

Doctor Murphy reported that research in the use of amphetamines or "speed" shows no proof that performances have been improved by the athletes.

The Ohio State team physician said that he does not recommend the use of oxygen on the football field or in any sport "because its value will last only 20-30 breaths or until the player gets back into the huddle." Some Big Ten Schools and professional teams do use oxygen, he reported.

If you've moved. . . .

Please attach the latest address label from the back cover of Michigan Medicine, print your new address here, and mail this form to the MSMS Membership Department. Please allow 30 days for the change.

- -

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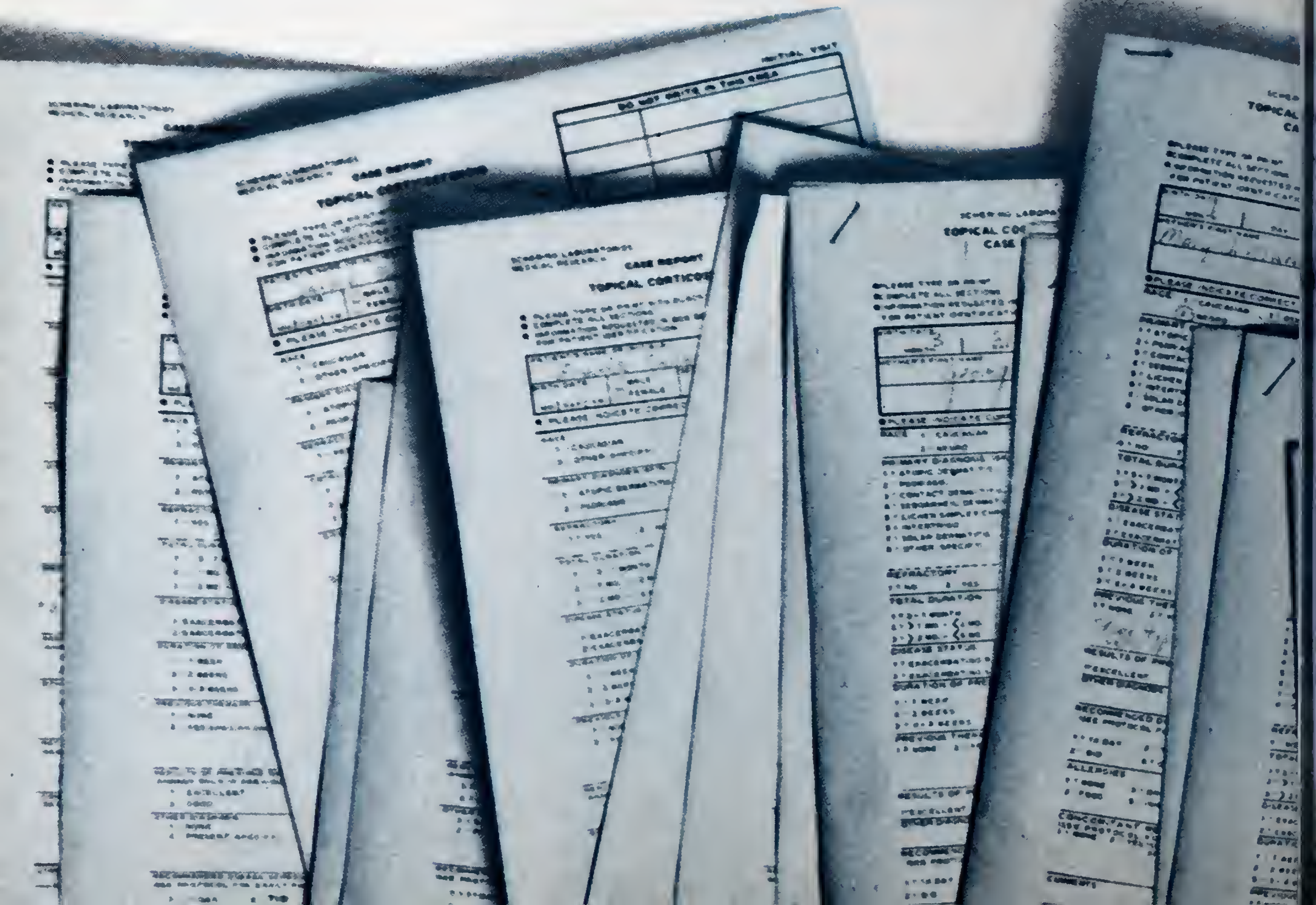
85% in psoriasis *(150 of 177 patients)*[1]

92% in atopic ecze *(231 of 251 patients)*[1]



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Plus economy *B.i.d. dosage often found effective!*
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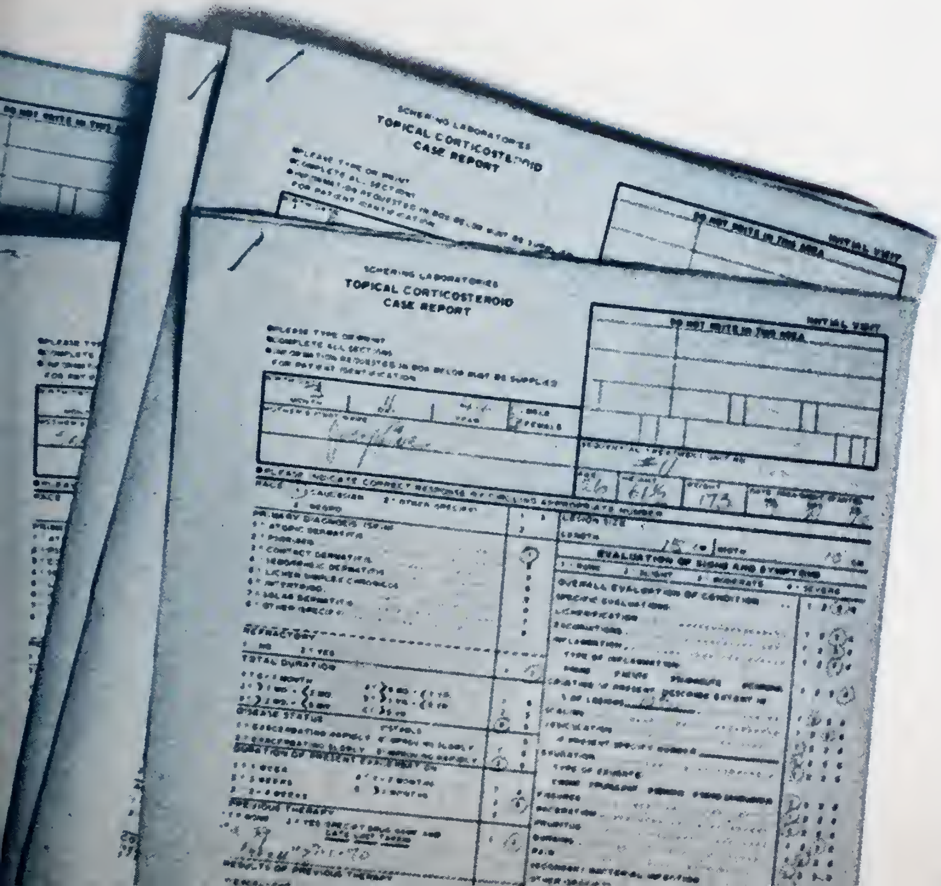
(81 of 84 patients)[1]



SCHERING LABORATORIES
TOPICAL CORTICOSTEROID
CASE REPORT

CLINICAL CONSIDERATIONS:

Description VALISONE products contain betamethasone valerate (9-fluoro-11_{β},17,21-trihydroxy-16_{β}-methylpregna-1,4-diene-3,20-dione 17-valerate). Each gram of VALISONE Cream 0.1% contains 1.2 mg. betamethasone valerate (equivalent to 1.0 mg. betamethasone) in a soft, white, hydrophilic cream of water, mineral oil, petrolatum, polyethylene glycol 1000 monocetyl ether, cetostearyl alcohol, monobasic sodium phosphate, and phosphoric acid; 4-chloro-m-cresol is present as a preservative. Each gram of VALISONE Ointment 0.1% contains 1.2 mg. betamethasone valerate (equivalent to 1.0 mg. betamethasone) in an ointment base of liquid and white petrolatum, and hydrogenated lanolin. VALISONE Cream and Ointment contain no parabens.

Indications VALISONE Cream and Ointment are indicated for the relief of the inflammatory manifestations of corticosteroid-responsive dermatoses.

Contraindications VALISONE Cream and Ointment are contraindicated in vaccinia and varicella. Topical steroids are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.

Precautions If irritation develops with the use of VALISONE Cream or Ointment, treatment should be discontinued and appropriate therapy instituted. In the presence of an infection, the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled. If extensive areas are treated or if the occlusive technique is used, the possibility exists of increased systemic absorption of the corticosteroid and suitable precautions should be taken. Although topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use in pregnant females has not been absolutely established. Therefore, they should not be used extensively in pregnant patients, in large amounts, or for prolonged periods of time. VALISONE Cream and Ointment are not for ophthalmic use.

Adverse Reactions The following local adverse reactions have been reported with topical corticosteroids: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneform eruptions, and hypopigmentation. The following may occur more frequently with occlusive dressings than without such therapy: maceration of the skin, secondary infection, skin atrophy, striae, and miliaria.

Dosage and Administration Apply a thin film of VALISONE Cream or Ointment to the affected skin areas one to three times a day. Clinical studies of VALISONE have indicated that dosage only once or twice a day is often feasible and effective. AUGUST 1972

For more complete details, consult Schering literature available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.

References: *(1) Files of Headquarters Medical Research Division, Schering Corporation. (2) Carter, V. H., and Noojin, R. O.: Curr. Therap. Res. 9:253, 1967. (3) Falk, M. S.: Cutis 2:788, 1966. (4) Goldblum, R. W.: Pennsylvania Med. 69:50, 1966. (5) Nierman, M. M.: J. Indiana M. A. 10:1184, 1966. (6) Zimmerman, E. H.: Arch. Dermat. 95:514, 1967.*

SLR-439

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1973 MECO report

Medical students complete successful summer in MSMS-coordinated program

The 105 medical students who took part in the 1973 Student American Medical Association Project for Medical Education and Community Orientation in Michigan have returned to classes after what was for many their first close look at community medical practice.

MECO, coordinated by MSMS for the fourth time this year, is a continuing success story.

"It was an enlightening experience and will certainly have a continuing influence on my future education," said Gregg Warshaw, a University of Michigan second year medical student who spent the summer in Saline Community Hospital. "The physicians at the hospital went out of their way to spend as much time with me as I asked for, and sometimes this surely meant extra hours of work for them."

"It's been a great learning experience," reported Victoria Nessel, a third year U-M medical student, of her MECO program in Bay City.

"I know I enjoy the teaching aspect very much myself," commented Alberto Cohen, MD, who supervised a program for two Wayne State University medical students at St. Joseph Hospital, Mount Clemens.

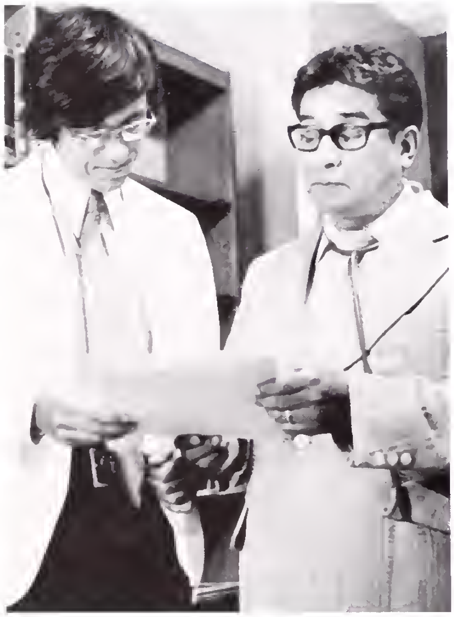
These comments are typical of the participating students and the physicians who directed their hospital based programs during the summer. Fifty-three hospitals took part and provided financial support for the program.

Two hundred fifty medical students have participated in the MECO program in Michigan since 1970. Of these, 16 have graduated from medical school. One is in a residency program in Ann Arbor and ten are interning in Michigan. Five are interning out of state.

Thirty-nine additional participants are to be graduated in 1974.

MSMS assists the program, in which students spend their summer vacations learning about medical practice in community hospitals under the supervision of practicing physicians, to encourage student interest in practicing in the state.

The program is to continue in 1974.



James Harrison (left), University of Michigan medical student from Crystal Falls, reviews medical records with Honorato Barrios, MD, in MECO program at St Joseph's Community Hospital, Hancock Hancock Daily Mining Gazette Photo

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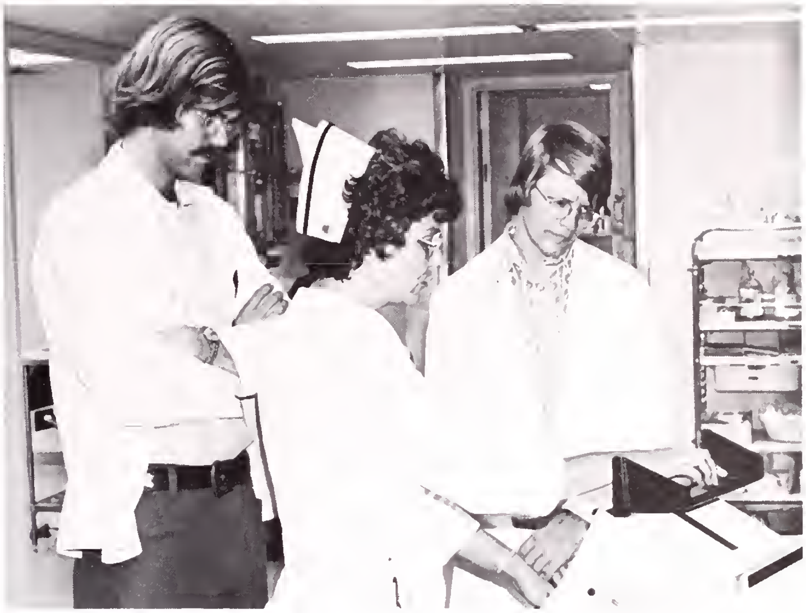
Introduction to emergency medical services in Bay City was part of the 1973 MECO program for Lorenz Kielhorn (left), Michigan State University medical student from Grandville; Gary Herzler (center), Wayne State University medical student from Saginaw, and John Putman, Jr., of Detroit, student at the Chicago College of Osteopathic Medicine. Bay City Times Photo.

Medical students Bruce Day (left), of Kalamazoo, and Craig Bade, of Holland, learn about defibrillator unit from Mary Bougie, emergency room nurse at Holland City Hospital, during SAMA-MECO program supervised by Carl Van Krimpen, MD. Day attends MSU and Bade is a student at Wayne State.



Mark Shebuski (right) U M medical student from Houghton learned about community medical practice in the 1973 MECO program at St Joseph's Community Hospital, Hancock under supervision of Forrest Larson MD (left) Hancock Daily Mining Gazette Photo

James Orosz (left), Wayne State University medical student from Flint, discusses medical report with Douglass R. Beck, MD, of Flint, during summer MECO program based at McLaren General Hospital. Flint Journal Photo.

Victoria Nessel, of Detroit, and David A. Wood, of Bay City third year medical students at U-M, study X-ray at Mercy Hospital in Bay City MECO program supervised by Paul W Rowe, MD Bay City Times Photo

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While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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Oct. 25-26—Fourth Annual Cardiology Symposium, "Concepts in Cardiology," sponsored by Cardiology Services, Borgess Hospital, Kalamazoo, at the hospital, contact: Robert P. Barcala, director, Cardiology Services, Borgess Hospital, Kalamazoo, Mich. 49001.

Oct. 29-Nov. 1—Interstate Postgraduate Medical Association Assembly, "Making Your Practice More Effective for You and Your Patients," Palmer House, Chicago, contact: Interstate Postgraduate Medical Association of North America, PO Box 5445, Madison, Wis. 53705.

Nov. 1—Annual Professional Symposium for physicians sponsored by the Kent County Unit of the Michigan Heart Association, Holiday Inn East, Grand Rapids, contact: Donald G. Wideman, Western Region Director, MHA, 2424 Burton, SE, Grand Rapids, Mich. 49506.

Nov. 13-14—MSMS and AMA Seminar on "Establishing Yourself in Medical Practice," MSMS headquarters, contact: Richard Campau, MSMS, 120 W. Saginaw St., East Lansing, Mich. 48823.

Nov. 28—Physician postgraduate course, "Human Hypersensitivity Disorders: Clinical Aspects and Pathogenetic Mechanisms," sponsored by American College of Physicians, at the U-M Medical Center, Ann Arbor, contact: ACP, 4200 Pine St., Philadelphia, Pa. 19104.

Nov. 28—Annual thyroid workshop sponsored by Thyroid Service of the Wayne State University School of Medicine, at Scott Hall, WSU, Detroit, contact: Howard Dworkin, MD, William Beaumont Hospital, 3601 W. 13 Mile Rd., Royal Oak, Mich. 48072.

Nov. 29—Professional Activity Study and Medical Audit Program Institute, sponsored by Commission on Professional and Hospital Activities, at CPHA headquarters, Ann Arbor, AAFP elective hours, contact: CPHA, 1968 Green Rd., Ann Arbor, Mich. 48105.

Dec. 1-4—AMA 1973 Clincial Convention on "New Dimensions in Continuing Education," Anaheim, Cal., contact: Clincial Convention Coordinator, AMA, 535 N. Dearborn St., Chicago, Ill. 60610.

Dec. 7-8—Twenty-first annual symposium on trauma sponsored by the Michigan committee on trauma of the American College of Surgeons and the Wayne State University School of Medicine, at Wayne County Medical Society headquarters, Detroit, contact: Joseph L. Posch, MD, Suite 1408, Kales Building, 76 W. Adams, Detroit, Mich. 48226.

Dec. 8—Seminar on "Diseases of the Endometrium and Uterus" sponsored by the Michigan Society of Pathologists, at Rackham Auditorium, U-M, Ann Arbor, contact: Jacob E. Briski, MD, St. John Hospital, 22101 Moross Rd., Detroit, Mich. 48236.

Jan. 15, 1974—Midwinter board meeting, MSMS Auxiliary, at MSMS headquarters, East Lansing, contact: Mrs. William J. Jones, president, 15839 Crescent Dr., Allen Park, Mich. 48101.

Jan. 16, 1974—Lecture on acupuncture by William M. Lukash, MD, White House physician, sponsored by William Beaumont Hospital Research Institute, at the hospital in Royal Oak, contact: Research Institute, Beaumont Hospital, 3601 W. 13 Mi. Rd., Royal Oak, Mich. 48072.

March 7, 1974—Professional Activity Study and Medical Audit Program Institute, sponsored by Commission on Professional and Hospital Activities, at CPHA headquarters, Ann Arbor, AAFP elective hours, contact: CPHA, 1968 Green Rd., Ann Arbor, Mich. 48105.

March 15-16, 1974—Second Annual National Conference on Human Nutritional Aspects of Kidney Disease and Renal Failure sponsored by the Kidney Foundation of Michigan, Michigan Renal Dietitians and the Michigan State University School of Nutrition, at Kellogg Center, MSU, East Lansing, contact: Ms. Jean Bruge, Michigan Nephrology Center, Borgess Hospital, 1521 Gull Rd., Kalamazoo, Mich. 49001.

March 18-21, 1974—Physician postgraduate course "Rheumatic Disease: Pathogenesis, Diagnosis and Treatment," sponsored by American College of Physicians, at U-M Medical Center, Ann Arbor, contact: ACP, 4200 Pine St., Philadelphia, 19104.

March 27-28, 1974—Annual Michigan Conference on Maternal and Perinatal Health, the Pantlind Hotel, Grand Rapids, contact: Lloyd Kammeraad, MD, 1810 Wealthy St., SE, Grand Rapids, Mich. 49506, or Helen Schulte, MSMS Headquarters.

April 24, 1974—Annual Legislative Day, MSMS Auxiliary, at Olds Plaza Hotel, Lansing, contact: Mrs. Robert J. Westerhoff, 2458 Maplewood, SE, Grand Rapids, Mich. 49506.

April 24-25, 1974—Annual Spring Conference, MSMS Auxiliary, at Hospitality Inn, Lansing, contact: Mrs. William J. Jones, president, 15839 Crescent Drive, Allen Park, Mich. 48101.

Michigan Mediscene each month lists upcoming meetings in Michigan or, if out of state, of special interest to Michigan physicians. Please submit meeting notices for listing at least two months prior to meeting dates to Michigan Medicine, 120 W. Saginaw St., East Lansing, Mich. 48823.

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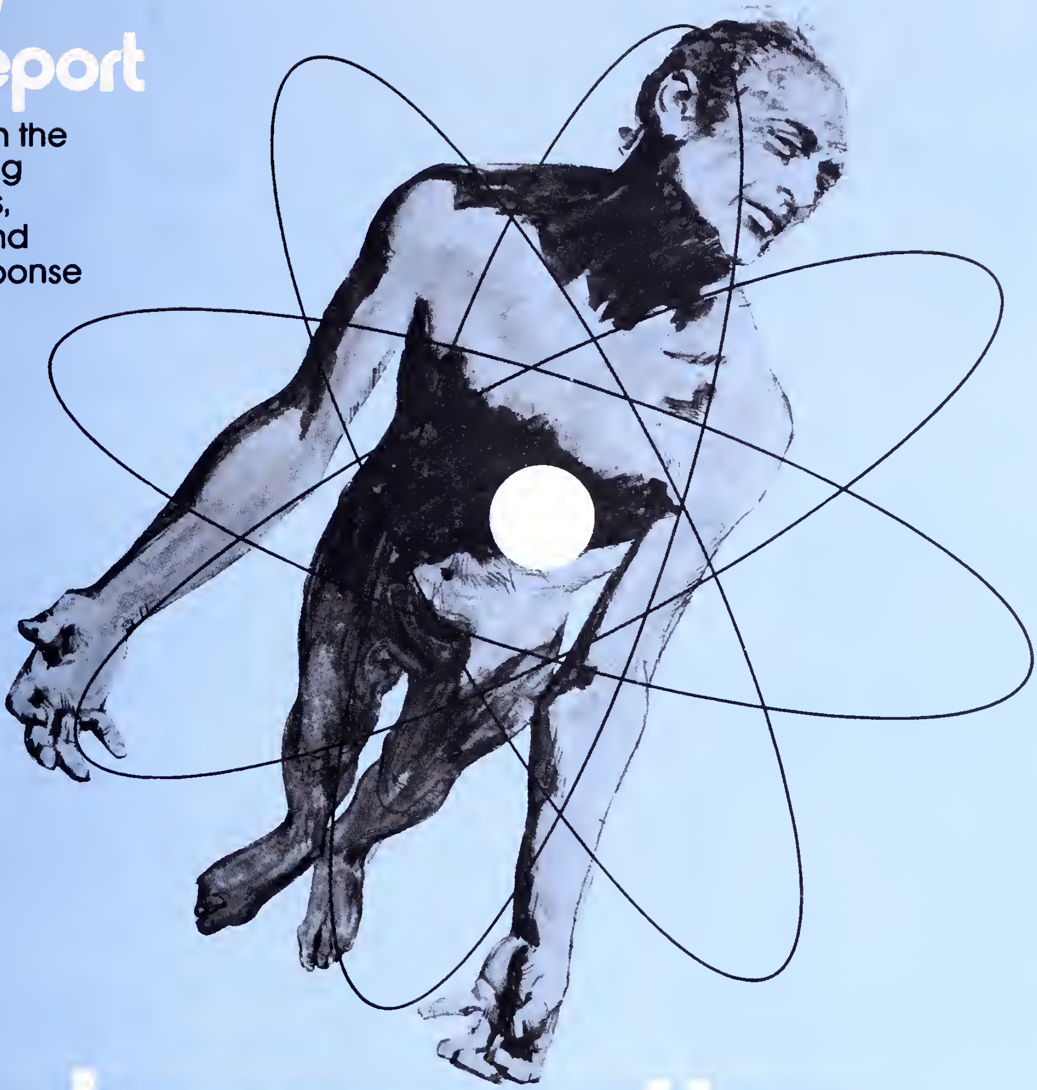

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Small doses

Donald J. Birmingham, MD, of Detroit,

has been appointed chairman of the department of dermatology and syphilology at the Wayne State University School of Medicine. He joined WSU as professor of dermatology in 1964 after retiring as dermatology section chief in the U.S. Public Health Service's Occupational Health Research and Training Facility in Cincinnati.

Craig E. Booher, MD, formerly of Grand Rapids,

is new assistant dean for continuing medical education at the Rockford School of Medicine, Rockford, Ill. He formerly was director of medical education at Blodgett Hospital, Grand Rapids.

Dean C. Burns, MD, of Petoskey,

was honored recently on his 50th anniversary in medical practice by a series of community events. Burns Clinic Medical Center presented a two-day seminar and a Founder's Day dinner to mark the occasion and the city of Petoskey on Aug. 16 celebrated Dean C. Burns Day, as proclaimed by the mayor.

Bruce H. Drukker, MD, of Detroit,

has been appointed chairman of the Department of Gynecology and Obstetrics at Henry Ford Hospital. Doctor Drukker's major research interests have been in the chemotherapy of gynecologic cancer in women.

Naim M. Raby, MD, of Southgate,

recently spoke on "Sudden Infant Death Syndrome" before the Wyandotte SIDS Chapter.

Paul H. Engle, MD, of Olivet,

has been honored as "Man of the Year for 1973" by the Olivet Chamber of Commerce. Doctor Engle practiced in Olivet from 1933 until 1956 when he began a ten year tour of duty with the U.S. Department of State Foreign Service. He was stationed in Pakistan, Iraq and the Philippines.

Marilyn Heins, MD, of Detroit,

has been promoted from assistant to associate dean for student affairs at the Wayne State Uni-

(Continued on page 742)

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Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

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1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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versity School of Medicine. Doctor Heins also is associate professor of pediatrics at WSU and on the staff of Children's Hospital. Earlier this year she was elected chairperson of the WSU Commission on the Status of Women.

Jack Hoogerhyde, MD, of Battle Creek,

has been honored by the Downtown Kiwanis Club of Grand Rapids for distinguished service to the community and to Kiwanis. Doctor Hoogerhyde was senior attending surgeon at Butterworth Hospital in Grand Rapids until August, 1972, when he became a physician-consultant at the Veterans Administration Hospital in Battle Creek.

Ray E. Helfer, MD, of East Lansing,

spoke on "Battered Child Syndrome" at a recent scientific program of the Kentucky Medical Association in Louisville. He is an associate professor of human development at Michigan State University.

Ruth Herrick, MD, of Lowell,

has retired after 42 years of the practice of dermatology in Lowell and in Grand Rapids. Doctor Herrick was one of the first woman physicians in Kent County.

Harry Maisel, MD, of Detroit,

has named associate dean for curricular affairs at the Wayne State University School of Medicine. Doctor Maisel joined the WSU faculty in 1964 and has been professor of anatomy since 1967, assistant dean for curricular affairs since 1971.

George D. Maniaci, MD, of Gladstone,

has been elected chairman of the Michigan Advisory Council on Mental Health Services, which makes recommendations to the governor and the legislature on immediate and long-range needs in the state's mental health program. Doctor Maniaci has served on the council since 1969.

Joseph R. Montante, MD, of Orchard Lake,

has been chosen president-elect of the Wayne State University School of Medicine Alumni Association. He was graduated from the school in 1940.

Bruce C. Olsen, MD, of Greenville,

served as an adviser for the Michigan Child Study Association's guide on "Childhood Diseases—to Treat or Not to Treat." This is one of seven subjects chosen for child study club discussions during 1973-74.

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Robert E. Pearson, MD, of Traverse City,

is on the faculty for the 16th Annual Scientific Meeting and Workshop on Clinical Hypnosis of the American Society of Clinical Hypnosis being held Oct. 16-21 in Toronto.

Adelbert Stagg, MD, and Elizabeth Stagg, MD, of Hartford,

were honored recently at a community wide gathering for 25 years of service to their community.

William C. Stewart, MD, of Kalamazoo,

is the new chairman of the neonatal and hospital care committee of the Michigan Chapter of the American Academy of Pediatrics.

H. C. Tien, MD, of Lansing,

director of the Michigan Institute of Psychosynthesis, has returned from a trip to Peking, where he studied modern Chinese medicine, society and contemporary life.

Paul V. Wooley, Jr., MD, of Detroit,

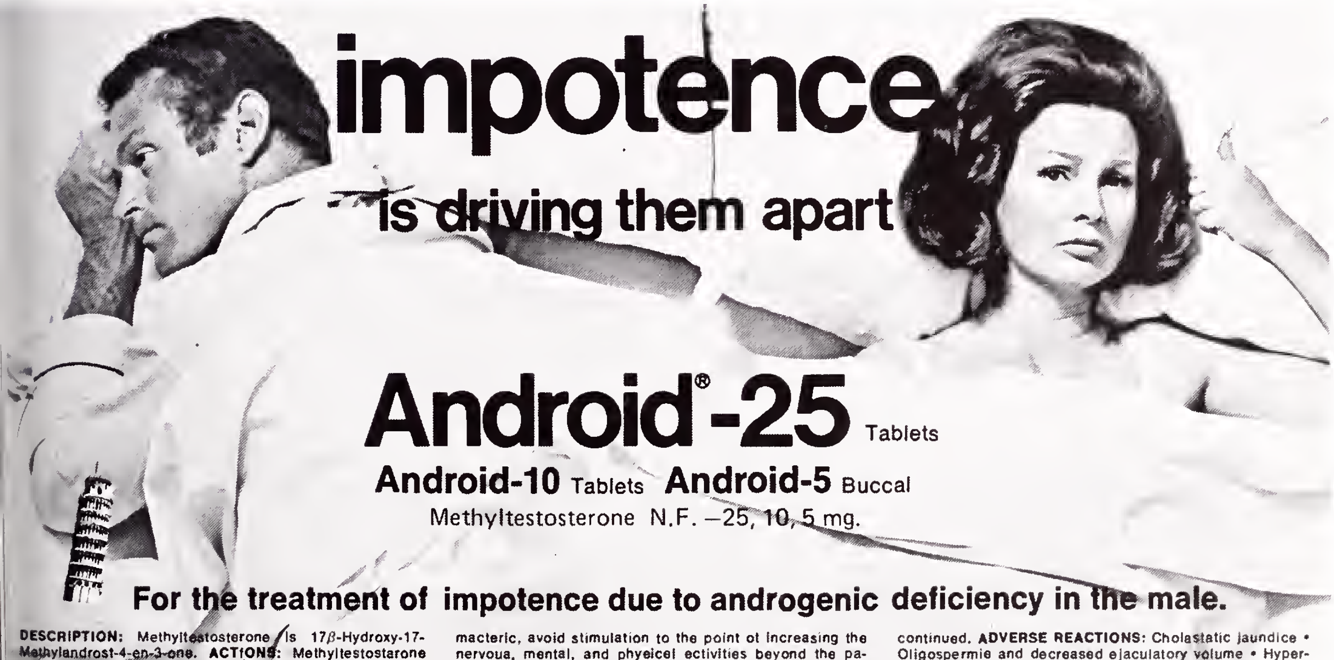
has announced his intention to retire next June as chairman of the Wayne State University School of Medicine Department of Pediatrics and as pediatrician-in-chief of Children's Hospital. His retirement will come at the conclusion of 28 years in these positions.

Three MSMS Members

have been cited by the AMA as members of the honor roll of physicians for serving as Volunteer Physicians for Viet Nam during the final year of the program. They are Robert F. Bort, MD, of Ann Arbor; Leonard M. Pickering, MD, of Southgate, and Hugh L. Sulfridge, MD, of Saginaw. The VPVN program, initiated in 1965, terminated last June 30 after 776 individual physicians served 1,029 tours of duty to provide health care to civilians.

Three Kalamazoo County Physicians

were among speakers at a leadership seminar held by the American Association of Medical Assistants—State of Michigan Sept. 22 in Kalamazoo. Taking part were Thomas R. Berglund, MD, of Portage and Richard Mellis, MD, and Russell E. Mohney, MD, both of Kalamazoo.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In memoriam

McClellan B. Conover, MD
Flint

McClellan B. Conover, MD, 61, of Flint, a specialist in internal medicine who devoted much of his career to work in physical therapy for the handicapped and to treatment and prevention of tuberculosis, died Aug. 6.

Doctor Conover, who received his medical education at Northwestern University, was the son of the late Thaddeus S. Conover, MD, of Flint, and the brother of George V. Conover, MD, of Flint.

Bruno C. Cook, MD
Westphalia

A physician in the Westphalia area for the last 42 years, Bruno C. Cook, MD, died July 31 at the age of 70. Doctor Cook was graduated from the University of Notre Dame and from the Wayne State University School of Medicine.

C. LeRoy De Land, MD
Bellevue

C. LeRoy De Land, MD, of Bellevue, who recently had been appointed director of emergency services at Community Hospital in Battle Creek, died Aug. 8. He was 60.

Doctor De Land received his medical degree from the University of Wisconsin in 1943 and had practiced in Bellevue and Olivet since 1948. He also had served as director of medical services for Olivet College. Doctor De Land held staff appointments at three Battle Creek hospitals and at hospitals in Charlotte and Marshall and was a past president of the Eaton County Medical Society. He was a lay leader in the Seventh Day Baptist denomination.

Charles Ward Ellis, MD
Port Blakely, Wash.

Charles Ward Ellis, MD, a retired Lansing physician who maintained homes in Port Blakely, Wash., and Hollywood, Fla., died Aug. 18 at the age of 94. He was educated at the Benzonia Academy and the University of Michigan Medical School, where he was a member of the class of 1904. He and his wife, Bertha W. Ellis, MD, a 1915 U of M medical graduate, practiced as eye, ear, nose and throat specialists in Lansing for many years.

Kenneth J. Feeney, MD
Lansing

A retired Lansing internist, Kenneth J. Feeney, MD, died Aug. 7 at the age of 65. A graduate of the University of Michigan Medical School, he had practiced in Lansing from 1943 until his retirement in 1972.

E. Fred Hafezi, MD
Ypsilanti

E. Fred Hafezi, MD, 57, Ypsilanti physician and surgeon, died Aug. 18. A medical graduate of the University of Teheran, Doctor Hafezi had practiced in Michigan since 1970. He was on the staff of Beyer Memorial Hospital in Ypsilanti.

Heinrich H. Handorf, MD
Northville

A Northville physician and surgeon for 40 years, Heinrich H. Handorf, MD, died Sept. 7 in Ann Arbor. He had been chairman of the medical advisory board of Northville Community Hospital for more than 20 years and also on the staff of Annapolis Community Hospital, Wayne, and Ypsilanti's Beyer Memorial Hospital.

Doctor Handorf received his medical education at the University of Hamburg, Germany, and began his practice in Michigan in 1924.

Kermit T. Johnstone, MD
Saginaw

Kermit T. Johnstone, MD, 65, of Saginaw, died Aug. 8. Doctor Johnstone began his medical practice in Saginaw in 1949 and was medical director of Central Foundry Division of General Motors Corp. until his retirement in 1970. For the last three years, he had been an emergency room staff physician at St. Luke's Hospital. Doctor Johnstone received his medical education at the University of Cincinnati.

Joseph A. Kasper, MD
Grosse Pointe

Head pathologist for 23 years at Bon Secours Hospital, Joseph A. Kasper, MD, of Grosse Pointe, died Sept. 8 at the age of 77. Doctor Kasper was graduated from the Wayne State University

(Continued on page 748)

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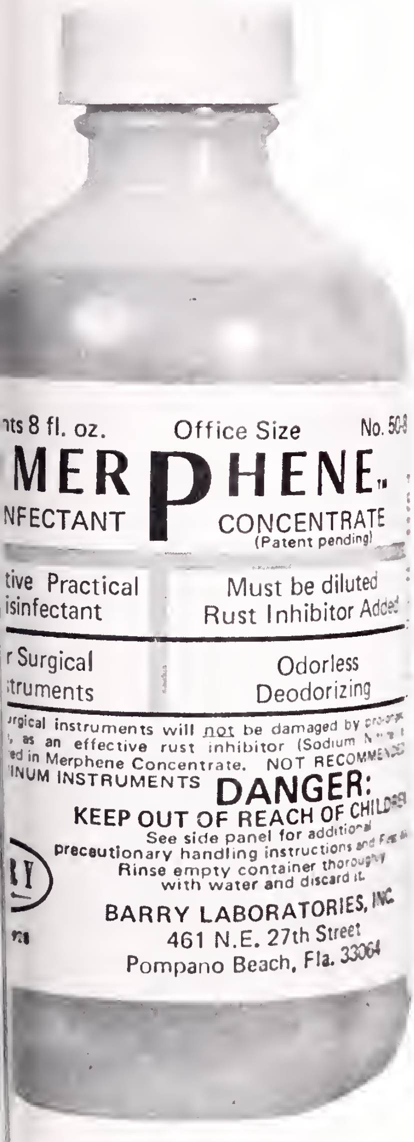

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OPTHALMOLOGIST—A very excellent opportunity for well-trained man, downtown Detroit, to join one-man office, worth investigating. Michael A. Wainstock, MD, 621 David Whitney Bldg., Detroit, MI 48226 (313) 961-7107 Office, (313) 864-2323 Home.

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WANTED: Fulltime staff physician for 320 bed hospital with rehabilitation, psychiatric and tuberculosis units. Michigan license required. Excellent salary and fringe benefits. Reply: Robert A. Clowater, M.D., Medical Supt. Saginaw Community Hospital, Saginaw, Michigan 48605.

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STAFF PSYCHIATRISTS: Community oriented State of Michigan agency. Affiliated with Wayne State University (faculty appointment available); active teaching program ongoing in all disciplines. Salaries range from $25,600-$33,500 (depending on qualifications) plus liberal fringe benefits. Apply: Medical Director, Detroit Psychiatric Institute, 1151 Taylor, Detroit, Michigan 48202.

UNIVERSITY HEALTH PHYSICIAN—ATHLETIC MEDICINE COORDINATOR: Staff position available for M.D. in Detroit. Position includes responsibility to athletic programs of the University plus general clinic duties. Competitive salary and fringe benefits including retirement and disability programs offered. Experience in managing athletic injuries desirable. For information send vitae to Andrew J. Smith, Jr., M.D. Director, Health Service, Wayne State University, Detroit, Michigan 48202. The University is an Affirmative Action/Equal Opportunity Employer.

OB-GYN, INTERNIST for additional staff with a well-established 15 man Medical Surgical Group in Detroit. Guarantee of $40,000 with excellent fringe benefits, security and growth. Reply Box #3. 120 West Saginaw Street, East Lansing, Michigan 48823.

PHYSICIANS WANTED: There is a vacancy for a physician interested in mental retardation. This is a state institution caring for some 2000 mentally retarded people. It includes a General Hospital, Laboratory, X-Ray, Dental, P.T., O.T., Speeck and Audiology Department. Fringe benefits include Medical and Life Insurance, sick leave, paid vacations, retirement benefits, etc. Michigan Permanent or temporary medical license required. Salary ranges from $23,970 to $33,512 based on qualifications. This is an equal opportunity employer. CONTACT: Isak O. Berker, M.D., Medical Director, Oakdale Center for Developmental Disabilities, Lapeer, Michigan 48446.

PHYSICIAN NEEDED: Inpatient and Outpatient work in active Student Health program. 40 hour week, no nights or weekends. Attractive fringe benefits. Equal opportunity/affirmative action employer. For more information, Contact Glenn O. Lease, M.D., Snow Health Center, Eastern Michigan University, Ypsilanti, Michigan. Call Collect (313) 487-1124.

WANTED: Department Chairman for the new Department of Family Practice at Michigan State University, College of Human Medicine, East Lansing, Michigan 48824. Must have experience in practice of Family Medicine. Ability to work effectively as a leader and cooperatively with faculty and community colleagues, including directors of four Family Practice Residencies, is imperative. Candidates should demonstrate a general interest in medical education and should show evidence of some productive scholarly activity and capability in the development and management of research. For details, write Thomas H. Kirschbaum, M.D., Chairman, Department of Obstetrics, Gynecology and Reproductive Biology, Michigan State University, East Lansing, Michigan 48823.

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NEW, BOARD APPROVED, CHILD PSYCHIATRY Fellowships offered in an innovative, established clinical program. Outpatient, Community Child Psychiatry and residential Treatment offer opportunities for a variety of treatment techniques. Crisis intervention ("life-space" interviews); behavioral therapy, pharmacotherapy; individual, group and family treatment methods; dynamic, social and developmental psychiatry taught. Learning by independent study, seminars, supervised experiences. Administrative experiences and training may be arranged. Multi-disciplinary staff including: six child psychiatrists, pediatrician, pediatric neurologist, psychologist, social workers, special education teachers, speech therapist, occupational therapists, recreational therapists and other consultants.

Program affiliated with the University of Michigan and a variety of clinical settings including: community mental health centers, child guidance clinics, etc. Salaries negotiable. Contact: William E. Kirk, M.D., Director, York Woods Center, Box A-6 Ypsilanti, Michigan 48197. Phone: (313) 434-3400. AN EQUAL OPPORTUNITY EMPLOYER.

Minority students at WSU receive aid

Two grants totaling more than $190,000 have been awarded to assist minority students at the Wayne State University School of Medicine. One grant, for $102,288, is made by the Robert Wood Johnson Foundation, and is to increase the number of future doctors to serve in inner city and rural areas. The other, for $88,558, is from the U.S. Public Health Service and is for a special health career opportunity program to increase the number of black physicians.

AMA VD statement available

Copies of a new Statement on Venereal Disease by the AMA Council on Environmental, Occupational and Public Health are available to interested members from MSMS headquarters. The statement emphasizes areas where concerned medical societies and physicians may focus their energies to combat the VD problem.

The MSMS Publication Committee urges MSMS members to study the pharmaceutcal advertisements in *Michigan Medicine*. The messages by these firms provide a regular source of drug information, the Committee points out.

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School of Medicine in 1919.

He was a past president of the Michigan Society of Pathologists.

Dorothy L. Leith, MD
Imlay City

Dorothy L. Leith, MD, of Imlay City, who at one time was Lapeer County's only woman doctor, died Aug. 8 at the age of 63. Doctor Leith was a graduate of the Wayne State University School of Medicine and had practiced in Imlay City for more than 20 years. She served two terms as Lapeer County coroner. Doctor Leith was a charter member of the American Academy of Family Physicians.

Malcolm D. MacQueen, MD
Detroit

Malcolm D. MacQueen, MD, a Detroit physician for 50 years, died Aug. 31 at the age of 80. A native of Canada, Doctor MacQueen served in the Canadian navy during World War I. He received his medical education at McGill University.

Doctor MacQueen was active in the medical insurance committees of MSMS and the Wayne County Medical Society. He was a board member and founder of the American Community Mutual Insurance Company of Plymouth and a member of the staff and the board of directors of Hutzel Hospital.

Leo L. Marston, MD
Lakeview

Leo L. Marston, MD, 66, of Lakeview, one of the founders of Kelsey Memorial Hospital in Lakeview, died Aug. 2 while en route home from a trip to the Upper Peninsula. Doctor Marston received his medical education at Marquette University and the Vienna School of Ophthalmology and had practiced in Lakeview since 1936. He and the late L. E. Kelsey, MD, founded Lakeview Hospital, later renamed to honor the memory of Doctor Kelsey. They gave the hospital to the community in 1956.

Doctor Marston served in the army during World War II.

B. Edward McNamara
Fairplay, Colo.

B. Edward McNamara, MD, of Fairplay, Colo., formerly of Lansing, died Aug. 24 at the age of 56. A graduate of Wayne State University School of Medicine, he was a specialist in industrial medicine. He formerly was on the staffs of St. Lawrence and Sparrow Hospitals in Lansing.

Antonio E. Ramos, MD
Warren

A Macomb County specialist in internal medicine, Antonio E. Ramos, MD, of Warren, died June 25 at the age of 43. He received his medical education from the University of Santa Tomas in Manila and had practiced in Michigan for eleven years.

Graham Sellers, MD
Troy

Graham Sellers, MD, of Troy, a member of the medical staff of Grace Hospital for 43 years, died Aug. 2. He was 66. Doctor Sellers was graduated from the Wayne State University School of Medicine. He was a native of Iroquois, Ont.

Lester J. Sevener, MD
Charlotte

Lester J. Sevener, MD, a Charlotte physician for 40 years prior to his retirement in 1969, died Aug. 6 at the age of 74. He received his medical degree from Loma Linda University.

Edward Kyle Simpson
Chatham, Ont.

Edward Kyle Simpson, MD, a former Pontiac physician and medical missionary in China for 13 years, died July 19 in Canada. He was 90. Doctor Simpson had lived in Chatham, Ont., since his retirement.

Doctor Simpson received his medical education at the University of Western Ontario and interned at Grace Hospital in Detroit before going to China as a missionary for the United Churches of Canada. He established his practice in Pontiac in 1928 and in 1962 received the MSMS 50 year award.

Ethelbert Spurrier, MD
Grosse Pointe Farms

A Detroit area surgeon for 46 years, Ethelbert Spurrier, MD, 74, of Grosse Pointe Farms, died July 24. Doctor Spurrier recently retired from the staff of the Veteran's Administration Hospital in Allen Park. He also had been on the staff of Harper Hospital and was professor of anatomy at the University of Detroit School of Dentistry. He served in the army in World War I and the navy in World War II.

Doctor Spurrier was graduated from the University of Michigan Medical School in 1925 and completed residency training in surgery at Billings Hospital in Chicago. He was a fellow of the American College of Surgeons.

'Health care for everyone'

Governor calls on physicians to help draw the 'blueprint' for state action

Governor William G. Milliken called for new leadership by the medical profession in planning to meet health care needs as he addressed the MSMS House of Delegates at the 1973 Annual Session Oct. 9 in Detroit. Following is the text of the governor's address.

I am pleased to have this opportunity to speak to the House of Delegates. On a number of occasions since becoming Governor, I have held discussions with individuals and small groups representing the Michigan State Medical Society. Our relationships have been especially cordial. We have been able to meet and work together both at times when there were problems to solve and at times when there were opportunities to explore the exciting implications of new technology and new directions in the field of medical care. These discussions have centered around specific concerns. Now I believe the time has come for us to talk about more basic issues.

The fact is that no subject is closer to the well-being of the American people than our system of health care. For every American, the quality of health care is literally a matter of life and death. As physicians, you know much better than I do how the life of every citizen turns on the competence, the availability, the technological capability of medical care. And, I should add, the life and health of every citizen also depends on whether he can afford to pay for the health care he needs and deserves.

Let's not mince any words. There was a time, in the highest councils of the American Medical Association, when a debate raged over the question whether medical care is a right or a privilege. As far as I'm concerned, and I would hope that as you're concerned, the debate is over. I am firmly convinced that every American, regardless of his income, regardless of his station in life, whether he lives in a city or on a farm—every American has a right to receive prompt, expert medical attention, at a cost he can afford.

For all of the criticism it has borne, I believe American medicine is the best in the world. The fact that our rate of infant mortality is greater than that of certain much smaller European countries—that fact proves little about the relative overall quality of American medicine. We have led the world in medical technology. We have led the world in research and innovation. We have led the world in the training of physicians and medical support personnel. And all of this adds up, it seems to me to the best medical care in the world.

I have been speaking about medical care in an overall sense, but the exceptions to what I have said are tragic and glaring. The level of quality, the system of health care delivery, the way in which health care is financed is, in many ways, seriously deficient.

The fact is that for too many Americans, health care is too expensive, and that is a problem that we need desperately to solve. Our goal should be, very simply, to make the highest quality health care available to every citizen, at a cost he can afford, and at a location he can reach with reasonable facility.

While significant advances have been made in emergency medical care, the quality of that care is often too low and too slow.

While privately financed health care plans—notably Blue Cross and Blue Shield—have performed remarkably well, we still have those tragic cases where a family's entire life savings are wiped out by a major illness.

(Continued)

Editor's note: The November issue of *Michigan Medicine* offers a special report on the 1973 Annual Session of the MSMS House of Delegates held in October in Detroit. On the cover, Gov. William G. Milliken addresses delegates.

These and other situations need to be corrected, to make economical, quality medical care available to every citizen of our state.

No government has been able to do this, and no government can. Government's role in medical care should be advisory, supportive, but not, I repeat, not dictatorial. Government can play a major supportive role, but it cannot, and should not, take over health care as its domain. We need the variety, we need the competitiveness, we need the independence which have permitted our private system of health care to become what it is today.

In all of this, state government is going to play an increasingly important role.

Government officials and those who provide health care are faced with the same problem: increasing public pressures for more health care services at reasonable cost. Many question the ability of the health care system to respond to these pressures. We're all familiar with the jaded phrase "health care crisis." Crisis or not, I am convinced—as I am sure many of you are—that we can and must find ways to extend and improve personal and family health care services throughout the country. To do this will require explicit public policies on health which we do not have.

What is the appropriate role of state government, in relation to the private sector, in the design and management of innovation and change in Michigan's health care system?

In your own lifetimes, you have seen profound changes in the role of government in health care. The point of departure was the Social Security Act of 1935. This provided federal grants-in-aid to states which required them to develop new public health programs, especially for mothers and children. An important pattern was established: The federal government provided the money—the states had to improvise ways and means to spend this money effectively.

The Public Health Service Act of 1944 greatly expanded the scope of services supported by federal grants-in-aid. By the end of World War II it was clear that successful provision of health care services was dependent upon continuing collaboration between the federal government, state governments, and the private sector. Congress acted by passing the Hill-Burton Act of 1946 (supporting health facilities construction); the Kerr-Mills Act of 1960 (authorizing medical assistance to the aged); and the Social Security Act Amendments of 1963 (providing maternal and infant care to low income families.)

There were still large groups of people with inadequate access to health care. The Medicare and Medicaid programs in 1965 represented a major attempt to make medical services available to all of our older citizens and to individuals and families with limited incomes.

Soon after these programs were in operation, it became apparent that additional money would not in itself be sufficient. Effective organization and delivery of medical care must be based on intelligent policy formulation and planning for resource development and allocation. Congress recognized this in enacting the "Partnership for Health" legislation in 1966, making it possible for states and regions within states to develop new health planning capabilities, with active consumer participations. This was the genesis of Comprehensive Health Planning—which has had a slow and painful beginning—but whose potential is now being recognized.

Government's role in the provision of health care has evolved in response to changing public expectations. We are all aware of how advances in science and technology have changed medical care. These advances have also evoked and shaped new dimensions in social attitudes. I have no doubt that State involvement will continue to increase.

I say this because of the nature and scope of several current developments. For example, state government now has direct influence over decisions which were only a short time ago the sole prerogative of the institutional provider. The state certificate of need and hospital finance programs, coupled with the federal economic stabilization and capital expenditure programs, give the state authority to encourage or, as needed, to prevent unnecessary facility construction and institutional price escalation.

The state has also become involved in the search for more efficient and effective means of delivering health care. One example is the Health Maintenance Organization. Based upon the progress of many of these organizations throughout the country, I am now prepared to act in support of HMO developments in Michigan. Between now and the first of the year, I will ask the Legislature to consider the Health Maintenance Organization Act, to be introduced at my suggestion. This act would establish the needed legal basis for HMOs and provide for their appropriate regulation.

In the search for new delivery mechanisms, the government has special opportunities and obligations. The task of providing adequate health care for the populations of our state institutions is one of these. I would like to tell you of two activities of immediate concern. The first is an attempt to solve the problems which have emerged as we move selected patients from large institutions for the mentally ill and mentally retarded to smaller community facilities. Recommendations from a study now being completed by the Office of Health and Medical Affairs will be submitted to me within the coming month and I intend to use these as the basis for making changes in this important program.

A second activity concerns the responsibility of providing adequate medical services in our correctional institutions. Last Thursday I announced receipt of a federal grant which will make possible design of a new health care system for these institutions—a system which will fully capitalize on existing resources and expertise. The Office of Health and Medical Affairs will be responsible for this task. I am happy to say that the Chairman of your Council, Doctor Robert Leitch, has already assured me that we will have the full support of the Michigan State Medical Society.

Efforts are being mounted to systemize the provision of intensive care services for high-risk mothers and infants, of transplant and dialysis services for patients with kidney disease and of emergency medical services through their organization on a regional basis. I believe that the state must vigorously promote such regionalization.

Education of health care professionals and creation of programs for new health workers are other areas in which the role of the state continues to grow. In recent years, our professional schools have undergone substantial expansion of facilities and curricula. Yet many contend that serious manpower shortages still exist in some communities throughout Michigan, justifying even greater expansion.

Others express the fear that within the near future we will be faced with surpluses in several categories. I believe it is fair to say that we simply do not know enough about health manpower supply, need and demand. A new approach to health manpower planning is needed. We must now systematically develop the data and methodology which will allow us to link output of our state educational institutions to manpower needs and demands of the health care delivery system. I am pleased to announce that this is underway. It is being undertaken in collaboration with health practitioners and with our institutions of higher education.

As public expenditures for health care increase, and the number of people affected becomes larger, so does the need for public accountability become more apparent. This need led the Congress to authorize creation of a nationwide network of Professional Standards Review Organizations. While a number of administrative difficulties will have to be overcome in establishing the PSRO system, it has the potential for improving public and professional accountability with regard to the cost and quality of medical care in the United States. State government will have an important part in the implementation of this concept and in its extension to all consumers of health care—not only those dependent upon public assistance.

Just as medicine and its technology are changing and thereby changing medical practice, so government must change to improve its techniques for supporting the provisions of human services.

Making the health care system function adequately for all citizens will require not only more money but better management. The federal government has money, but lacks the authority or capacity to manage health care. The state has the authority but lacks the money. It does have constitutionally derived powers to influence the condition under which services are provided. The responsibility of the federal government must be to establish broad national policies for health care. In the future, grants-in-aid should reflect national priorities and not simply represent partisan responses to immediate pressures.

State government has a different responsibility—to bring order and direction to the health care system within the state. As a means of accomplishing this, it must establish state health policy in a framework which involves all segments of society; manage health care resources to assure optimal utilization; and administer incentive and appropriate controls to guide the actions of consumers and providers.

Relationships between the public and private sectors must become closer; reluctant cooperation is not sufficient. We must together define publically accountable actions of health care institutions, practitioners and third-party payers and then design the means to supervise those actions.

At the state level, management of the health care system is the most important arena within which to work out productive relationships between the public and private sectors.

Controlling the quality and cost of health care, assuring the best use of our resources, promoting alternative systems of delivery and improving the distribution of specialized health services cannot be accomplished without the expertise and full cooperation of professional providers of care. The next five years are crucial. We especially need your leadership now.

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STEPPING DOWN FROM THE MSMS PRESIDENCY, JOHN J. COURY, MD (left), of Port Huron, passes the MSMS chain of office to Brooker L. Masters, MD, of Fremont, who will serve as president until the spring of 1975. Doctor Coury called for unity as he addressed the House of Delegates on Oct. 8. Here are excerpts from his address.

John J. Coury, MD:

"On many previous occasions I have pleaded for greater unity within the profession. I continue to plead, but more strongly than ever before. My experiences during this past year confirm my impression that our survival as a viable organization of the future will result only if we are a highly-unified profession able to speak authoritatively for our members.

"No longer can we bathe in the luxury of complete individualization at the expense of the profession as a whole.

"We cannot tolerate the factionalism between the generalist and the specialist, between the rural and the urban, between the practicing and the academic, between the black and the white and between the young and the old. We have the common goals of quality health care—and of mutual respect. We have the first, but where is the other?

"Let me assure you, from my experiences the past year, I am convinced there are strong and viable forces here in Michigan that are dedicated to changing our entire system of health delivery. They are organized, dedicated to their cause, financed and able.

"We must be ever mindful that unity includes also a strong local county society, a strong MSMS and a strong AMA."

Inaugural address

New president details physicians' role in improving quantity and quality of care

Brooker L. Masters, MD, of Fremont, outlined what he believes physicians and the Michigan State Medical Society should do to meet today's challenges as he gave his inaugural address after his installation as MSMS president Oct. 8 in Detroit. Following are excerpts from his address.

As we survey the problems of medical care delivery, foremost among them is the issue of our sensitivity and responsiveness to patient needs, desires and demands. The time is past when physicians could operate from the level of Mount Olympus relying upon a mystique alone to hold the patient enthralled. As our knowledge and control of the forces of disease have increased, so has our aura of impregnability decreased. If medical science and training have made great strides in the past quarter century, so also have the sophistication and knowledge of the patients we treat. The father-deity approach will no longer suffice. Patients now consider it their rightful heritage to receive the benefits of medicine's great scientific advances.

Health is the cornerstone of the good life. For without health, life means little, and the good life is the life for all. Unless we understand and accept this concept of equal health opportunities for everyone, unless we react sympathetically to developing patient attitudes of personal worth and dignity, unless our medical schools instill in budding physicians a real sensitivity to the needs of the public, our opportunities to direct health care will be diminished if not eliminated.

We frequently remark that in the face of rising public demand and at a time of shortage of personnel, the public and the public's elected representatives must act generously and responsibly. But charity begins at home! As members of the House of Delegates and the MSMS Council, what can we do to improve the delivery of health care in Michigan? To be sure, you will say that we have already been delivering health care to the people of Michigan for 108 years, but we must work in new areas today.

Social issues of the present cannot be met with the responses of the past. The winds of change blow strongly, and we must bend with the wind, or we must fall under the force of the blast. We must study the issues; we must prepare plans of work. And most of all, we must convince all doctors to accept more responsibilities in this area.

We are all aware that many areas of Michigan do not enjoy adequate medical coverage. Specifically, we need more family physicians, and we need them more equitably distributed. In my home county of Newaygo, we have one doctor for every 3,000 people. In one of the neighboring counties, not so rural, the ratio is one doctor to every 200 people. And if the needs of rural counties are inadequately met, certainly the medical care of the inner cities is more inadequate still.

Doctors of all kinds are in short supply there, but family doctors, especially, are urgently needed. Certainly the people of Michigan and their legislators feel this need for more family doctors. In 1972 there were 48 doctors in family practice residency programs in Michigan. At the same time there were 341 in general surgery residencies. Who in Michigan should decide how many specialists we train and how many primary physicians, or where we train them? If the medical profession and the medical centers cannot come to grips with this inequity and take steps to reduce it, we will forfeit our right to do so.

But there are other gaps in quantity of care. Given the doctors we need, and in the places we need them, too little attention is still given to preventive care. We must intensify our efforts in child health, nutrition, immunization, etc. And while MSMS is doing this, we must convince our patients that they too have some individual responsibilities for their own good health. Obesity, alcoholism, drug addiction are the doctors' anathema because there is no treatment, no magic potion that can solve these problems. Only the patient himself is responsible for these diseases

(Continued)

and he must be told so.

We must influence the medical schools to modify the attitudes that their training instills in students. In our day we were trained to be individualists, go our own way.

Today's doctors must be trained to work effectively with the growing numbers on the health team. We are no longer lonely paragons working in solitude. Young physicians must learn to captain the team so that under competent direction, the many para-medical personnel may fill the present void of health care. And I repeat they must be aware of their patients as individuals. I challenge the MSMS Education Liaison Committee to do more than provide a common meeting ground for town and gown but to play a stronger role in providing guidance, and of challenging the deans to respond to concerns to be identified by practicing doctors.

The three component societies with medical schools in their counties have untold opportunities to find new ways of working effectively together.

There is presently a loud hue and cry for "quality medical care." What does this mean? What is quality care? How do we measure it, and who shall do the measuring? It seems obvious that only those who are trained in medical care are competent to judge the quality of such care. Unfortunately, we have been reluctant to exercise control in this respect. The Hippocratic Oath states that all physicians are brothers, and we have been blinded by the beauty of this brotherhood. Our responsibility has always been, and always must be, to our patients.

We doctors of medicine and osteopathy must review our quality control measures, and we must make them work better. If we do not monitor the quality of care, some lay group will do it for us. Almost daily some new report is released, floating grandiose ideas of how these groups would go about it. We must not default this responsibility! The percentage of incompetent physicians is small. Our overriding responsibility is to place the public good above our personal reluctance to act.

The proposed new Michigan medical practice act would give the state new tools with which to attack this problem. We must actively support the adoption of this act by the state Legislature.

Hand in hand with these efforts must go refinement of our approaches to continuing medical education. Those of us who have worked with recent graduates of the medical schools are sharply impressed with the advances being made almost daily in medical treatment. As we pursue our busy schedules, time must be allotted and opportunities must be offered for further training in these advances. Here again, the profession must move in responsible ways, or others may be writing the examination that we must pass for re-licensure.

But beyond the problems of quantity and quality of care is the cost of that care. In 1974 I will work hard to explain to lay groups and others the many ramifications of medical care costs. The public must be told that from the high costs of the Medicaid program, only 13 cents of every dollar is paid to the physician. Our profession must not absorb all blame for rising health care costs. The same labor unions or teacher's associations that strike for higher wages must be made aware that the thousands of hospital workers in Michigan have the right for better salaries too, and that those salaries form a major part of medical care expense.

The wild schemes for national health care promise everything with little mention of cost. Somehow the public must be made aware that "there ain't no free lunch, and never was." At the same time, we must find a way to ease the worst financial burdens of illness. MSMS must study the many approaches to government medical care programs and find one that will help solve the problems of chronic illness and catastrophic health problems. The affluent can handle these emergencies; and the Medicare and Medicaid programs help the disadvantaged; but in my home town the factory workers, the clerks and the farmers cannot pay for catastrophic illness without financial ruin.

Third-party payers are here to stay, but we must take a stronger role in determining by which ground rules we will play the game. It was a year ago that this House of Delegates decided to negotiate with the State Department of Social Services in regard to some of the machinery being established for the Medicaid program. With that decision MSMS proved a viable force. Changes were made so both the public and the doctors were better served.

As we talk about the costs of medical care, we should ask, "What is a life worth?" If that life is yours, or that of a member of your family, there is no limit to the value you will place upon it. You want the most sophisticated medical care that is available. Such care does cost more. Complicated medical equipment and specially trained personnel are vastly more expensive than a helpless, hopeless vigil beside the sickbed. Likewise, new and efficient drugs cost more than aspirin, but their efficacy is such that the worker can be returned to his job more quickly, with less loss of pay. Many examples could be given of rehabilitation programs that restore people to richer and fuller lives, but all these programs cost immensely more than when we had nothing with which to help.

MSMS has a relatively new Bureau of Economic Information that is producing new studies. Using this information some of our committees can now move forward on a solid footing. To help more doctors deal effectively with the economic aspects of

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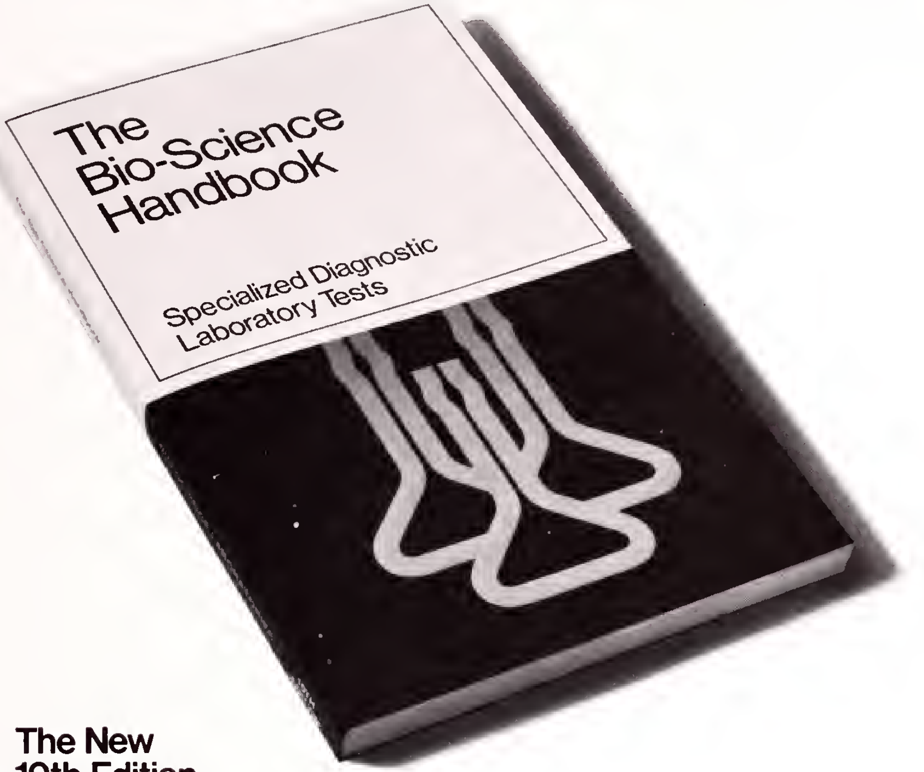

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Zip code 48823

Regular medication called best treatment for tuberculosis

Letter to the Editor:

Reply to letter from Chester S. Koop, MD
Vol. 72, No. 30, October, 1973

Since my previous communication was published in the July issue of *Michigan Medicine* we have completed statistics for the second half of 1971 demonstrating the same good results we achieved during the first half of the year.

The references I quoted in my article hinted (essentially proved) that the fate of a given tuberculosis patient depends on the regularity of the taking of medication, with all other factors being of negligible importance. To be a proponent of a sanitarium system, one must believe that the average patient with tuberculosis, presented with knowledge about his disease and the importance of taking his medication, will choose not to do so. We feel we have shown that this is not the case.

In my career as an internist practicing pulmonary disease, I have heard the question asked on two occasions of proponents of the sanitarium system: "If you yourself had tuberculosis, would you remain separated from your family for 6-12 months while you received treatment?" Each answered "No. I could take care of myself at home." If they could take care of themselves, why not others?

Of interest, the two other major institutions in Wayne County caring for tuberculosis patients now follow a philosophy similar to ours with respect to who is discharged and when. Together we represent the treatment of more than 50 percent of all new cases of tuberculosis in the state of Michigan each year.

The age of the sanitarium makes a brilliant chapter in the history of medicine. On the other hand, we accept a ride at 600 miles per hour in a spacious 747 jet to Hawaii without contempt for the Wright brothers' meagre attempts to fly in nothing more than a large box kite; can we not accept the truly remarkable change in pulmonary medicine which chemotherapy has provided, and let the old system, now a 'horse-drawn carriage' of medicine, pass away?

Sincerely yours,
Philip G. Cramer, MD
Wayne County Health Dept., Eloise

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Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.
Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.
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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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The Weight of Professional Opinion

It's time for action to defend the law and regulations that protect your patients against drug substitution.

These professional and trade organizations are united in supporting antisubstitution statutes and regulation

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American Academy of Family
Physicians

The Executive Board of the
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The Committee on Drugs of the
American Academy of Pediatrics

The American College of Allergists

The Executive Committee of the
American College of Obstetricians
and Gynecologists

The Board of Regents of the
American College of Physicians

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American Dental Association

The Board of Trustees of the
American Medical Association

The American Psychiatric Associat

The Executive Committee of the
National Association of Retail
Druggists

The Board of Directors of the
Pharmaceutical Manufacturers
Association

The National Wholesale Druggists'
Association

nt Statement on Antisubstitution Laws and Regulations

The purpose of this statement is ffirm the support of the participat- organizations for the laws, regula- s and professional traditions which hibit the unauthorized substitution rug products.

Traditionally, physicians, den- s and pharmacists have worked peratively to serve the best inter- s of patients. Productive coopera- has been achieved through tual respect as well as a common cern for the ideals of public vice. This mutual respect has been ected, in part, by joint support r the years for the adoption and orcement of laws and regulations cifically prohibiting unauthorized stitution and encouraging joint cussion and selection of the rce of supply of drug products. basic principles of medical, den- and pharmacy practice are thus ized and preserved in the interest atient welfare.

The antisubstitution laws have obstructed enhancement of the fessional status of pharmacy any e than they have in and of them- es guaranteed absolute protec- from unsafe drugs, or freed sicians, dentists and pharmacists n their responsibilities to patients. practical matter, however, such s and regulations encourage inter- fessional communications regard- drug product selection and assure h profession the opportunity to rcise fully its expertise in drug ge, to the advantage of patients.

Physicians and dentists should rged to increase the frequency regularity of their contacts with rmacists in selection of quality g products, recognizing that economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

Pharmaceutical Manufacturers Association
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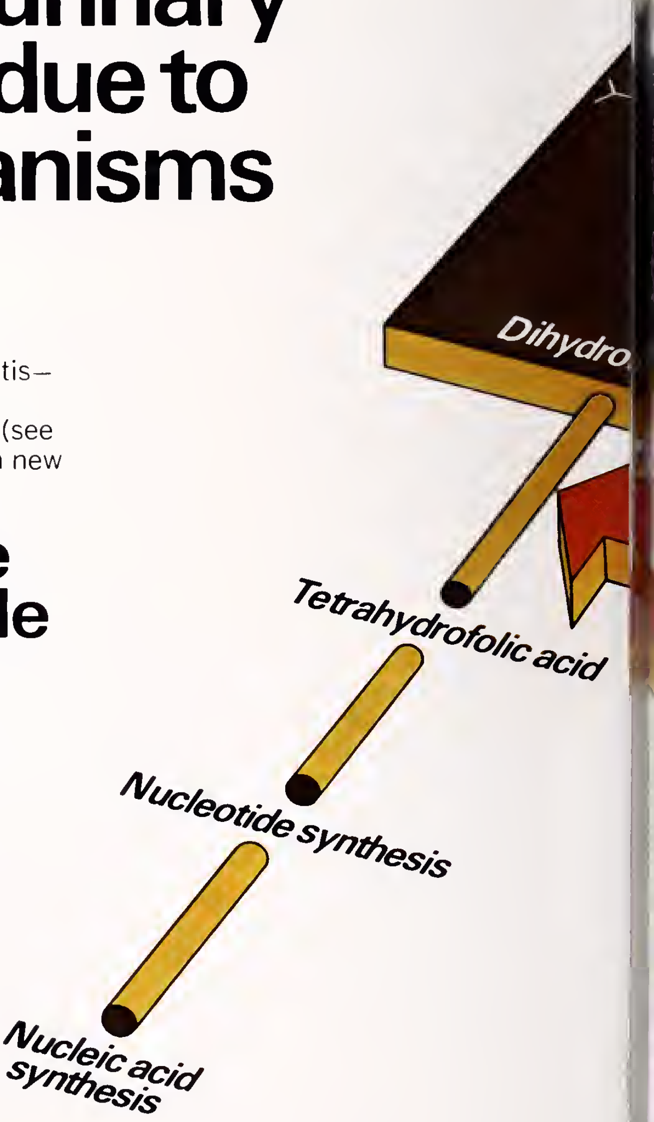
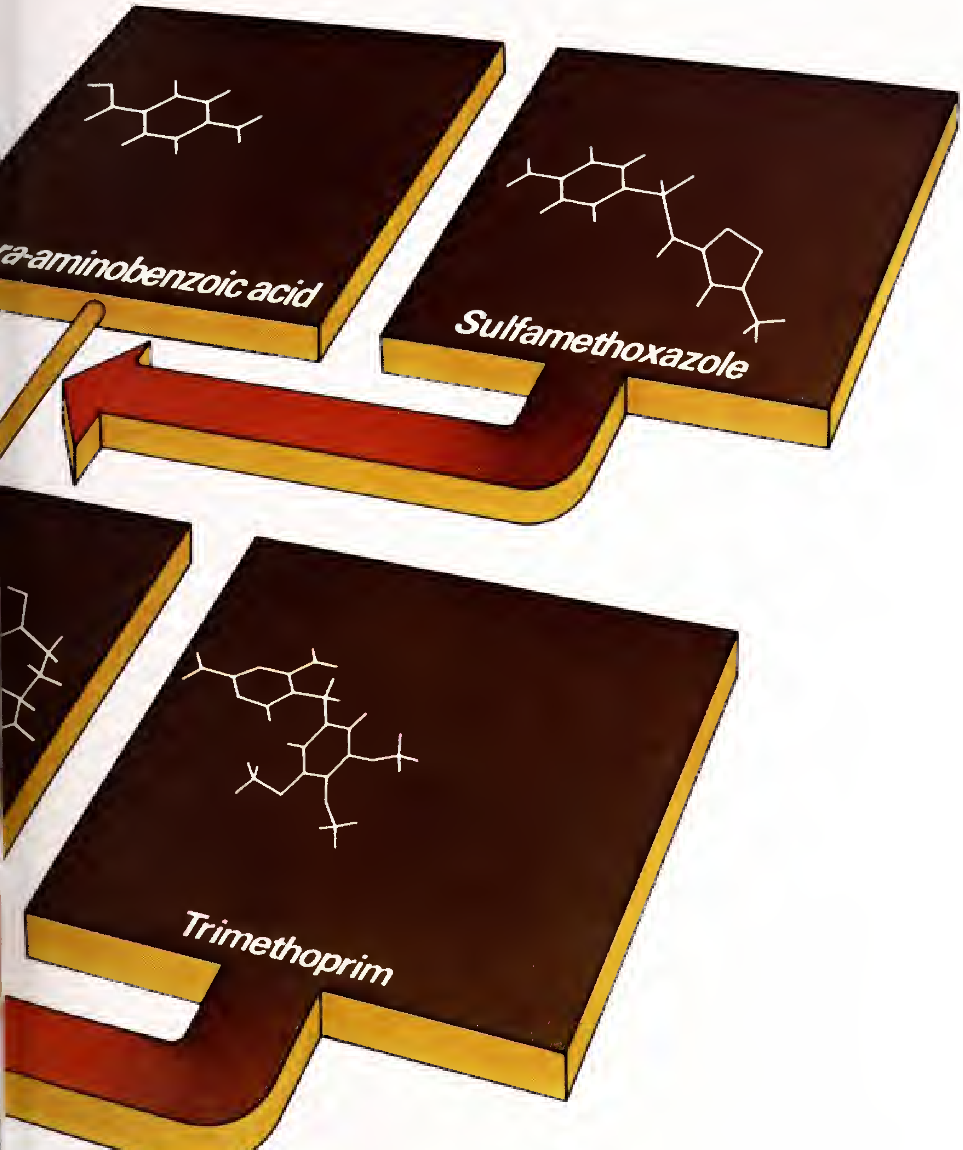
a new type of antibacterial for a two-pronged attack against chronic urinary tract infections due to susceptible organisms

Bactrim is highly effective in the treatment of these infections—primarily pyelonephritis, pyelitis and cystitis—when due to susceptible organisms. This efficacy is related to the unique mode of action against bacteria (see illustration), an action that, in effect, makes Bactrim a new type of antibacterial.

Bactrim interrupts the life cycle of susceptible bacteria

Unique mode of action interrupts the life cycle at two important points, thereby impeding the production of nucleic acids and proteins essential to these bacteria. These consecutive interruptions occur because sulfamethoxazole and trimethoprim resemble naturally existing substrates. By competitive replacement of these substrates, they inhibit further synthesis.




ra-aminobenzoic acid
Sulfamethoxazole
Trimethoprim

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for chronic urinary tract infections

Before prescribing, please see complete product information on last page of advertisement.

Excellent clinical response in chronic urinary tract infections even with obstructive complications

A multiclinic, double-blind study* of response to a ten-day course of therapy in 471† patients with chronic urinary tract infections demonstrated the superiority of Bactrim. On the 10th day after initiation of therapy, 91.7% (of 168 patients) showed significant bacteriological response to Bactrim, compared with 81.2% (of 144 patients) to trimethoprim and 64.5% (of 155 patients) to sulfamethoxazole. More than half of these patients had obstructive complications.

Excellent response maintained

Bactrim proved equally impressive in maintaining this bacteriological response. In the above study, after a ten-day course of therapy with Bactrim, 68.4% of patients with chronic urinary tract infections *maintained* response for up to 42 consecutive days, compared with 59.7% with trimethoprim and 44.4% with sulfamethoxazole. These results are particularly noteworthy considering the number of patients with obstructive complications — cases regarded as being notoriously difficult to treat.

Prescribing considerations

Clinical Limitations: Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections. Not recommended for children under twelve.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period.

Warnings and Precautions: Both sulfamethoxazole and trimethoprim have been reported to interfere with hematopoiesis. Complete blood counts should be done frequently. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued. Bactrim should be given with caution to patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. Maintain adequate fluid intake. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Effects: Among the most common side effects are nausea, vomiting, rash, leukopenia and elevations in SGOT and creatinine.

Usual adult dosage: two tablets every twelve hours for 10 to 14 days; no loading dose required.

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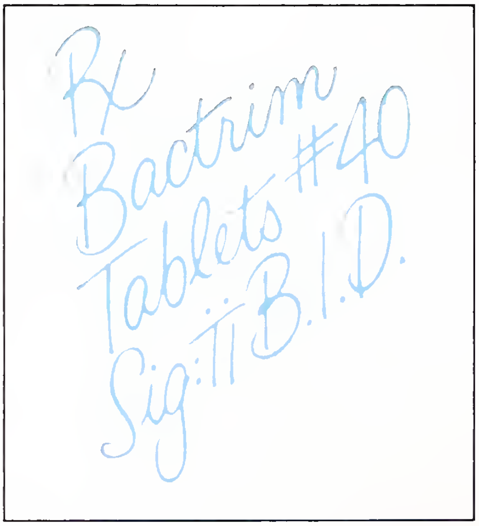
*Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110

† 4 patients not available for evaluation at day 10.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Bactrim
Tablets #40
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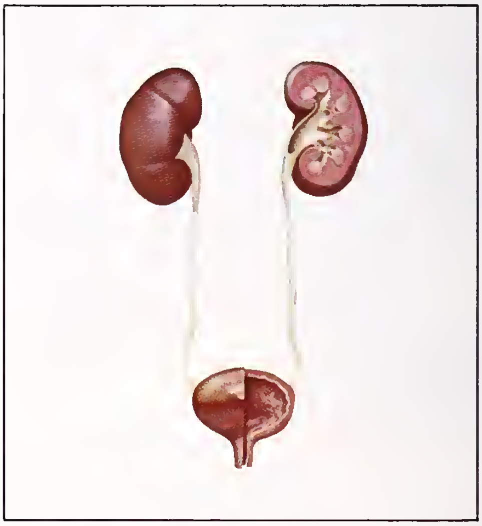

new **BACTRIM**™

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for chronic urinary tract infections

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Before prescribing, please consult complete product information on facing page.

Complete Product Information:

Description: Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. It is a white to light-yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is N^1-(5-methyl-3-isoxazolyl)sulfanilamide. It is an almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

Actions: *Microbiology:* Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with *para*-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

In vitro studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

In vitro serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa.* The following organisms are usually susceptible: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis* and indole-positive proteus species.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms
(MIC—mcg/ml)

Bacteria	Trimethoprim alone	Sulfamethoxazole alone	TMP/SMX (1:20) TMP	TMP/SMX (1:20) SMX
Escherichia coli	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
Proteus spp. indole positive	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
Proteus mirabilis	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
Klebsiella-Enterobacter	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

Human Pharmacology: Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. On repeated administration, the steady-state ratio of trimethoprim to sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma decreases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than are the concentrations in the blood. When administered together as in Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species).

***Important note:* Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.**

Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period (see Reproduction Studies).

Warnings: Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombopenia with purpura has been reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

Precautions: Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Reactions: For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

Blood dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

Gastrointestinal reactions: Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

C.N.S. reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

Miscellaneous reactions: Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

Dosage and Administration: Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

How Supplied: Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

Reproduction Studies: In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

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Some people advocate major displacements in the existing system. I do not. The real challenge facing us in the 1970's is to assure that future developments in health care conceived and implemented in a rational manner—with the clearly defined goal of making the pluralistic American health care system achieve its full potential.

What we seek is adequate health care for everyone. This will not happen overnight. It cannot be done by providers, by unions or by government alone.

Various national health care schemes are under consideration in Washington. None of them is adequate. I believe we have an opportunity to contribute to the debate over the future of the Nation's health care system. As this debate proceeds, there are a number of measures which I would like us to consider for implementation in our own state.

—Should we establish minimum standards for health insurance sold in Michigan?

—Should all employers be required to provide health insurance for their employees?

—Should the State's Certificate of Need Program be expanded to include all institutional providers?

—Should we establish a state pool for medical malpractice insurance?

These are not partisan questions. Nor are they separable. They must be considered in relation to one another and to developments which I described earlier.

I want you to know that I will be tackling these issues during the coming months. My objective is to complete formulation of a set of explicit state health policies by the fall of next year. I look to the State Health Planning Advisory Council as the principal body for determination of these policies. An outstanding member of the Society is on the council—Doctor John Coury.* Through him, and through your own committees working jointly with the council, you have the means by which the private sector can assume a major role in the formulation of public policy and in delineation of state government's role in the health care system. I have seen Doctor Coury's presidential address and I am pleased that he shares this view.

Although it is an essential forerunner to innovation and change, policy is meaningless in the absence of concrete action. The next step will be to develop a blueprint for converting policy into action. When I say "blueprint," that is exactly what I mean. I take this opportunity to publically challenge organized medicine, other provider associations, our professional schools and consumer groups to devise realistic implementation strategies for the regionalization of health services in addition to those already underway.

Specifically, I would like your responses to the following questions:

—What services could better be provided on a regional as opposed to a communtity basis?

—What manpower, facilities and special equipment would be required?

—How should they be financed?

—How would consumers know about these services and how could they reach them?

—What role should areawide comprehensive health planning agencies and PSROs perform in the design and operation of these services?

Your ideas could be appropriately transmitted in the form of working papers. I suggest that these papers be submitted to my office on or before Dec. 30, 1973. Beginning in February of next year, I propose that we sponsor a series of technical conferences on regionalization, using these papers as a basis for discussion.

I envision this as being the first in a series of implementation studies. Cost containment may be the next.

Your participation in this effort will be crucial to its success and to the prospect of continuing collaboration between the public and private sectors in responsibly promoting innovation and change in Michigan's health care system.

**After the governor's presentation, John J. Coury, MD, MSMS immediate past president, was named to head a special task force to develop working papers answering the questions posed by Milliken. Doctor Coury has asked that members submit comments to him at the MSMS headquarters.*

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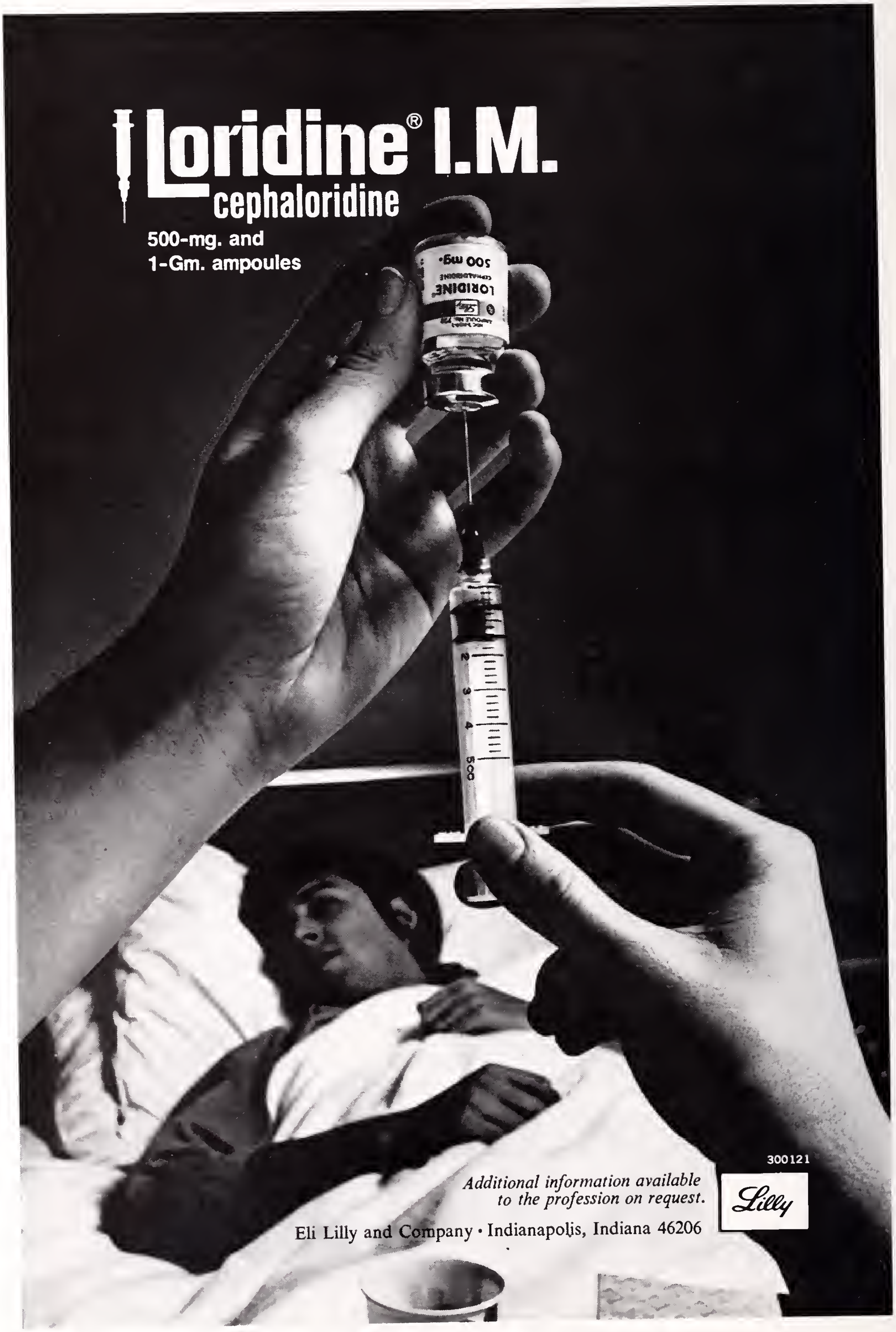

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Thrombophlebitis and pulmonary emboli following vasectomy

By William J. Alt, MD
Muskegon

A patient with thrombophlebitis and pulmonary emboli following vasectomy is described. There was no other cause for the thrombophlebitis found. The patient recovered completely and without recurrence, with appropriate treatment. Although the incidence of thrombophlebitis following vasectomy remains unknown, physicians should be alerted to this potential complication.

Currently vasectomy is widely performed and advocated as a means of contraception. Jackson, et al., summarized the operation as "simple, safe, esthetic, efficient and cheap."[1] Up to this present report there has been no instance of a documented systemic complication.

Report of a Case

This 40-year-old white male had a vasectomy as an outpatient Nov. 7, 1971. He was seen postoperatively by his surgeon and there was no evidence of hematoma or infection. Five days after his operation the patient stated he had a "cramp" in his left leg. He did not seek medical attention for this and did not report it until his second hospital admission. The discomfort was aggravated when he was up and about for the day and was relieved somewhat when he kept his foot elevated; e.g., on the desk at work. Approximately four or five weeks after the onset of this "cramp" the symptom disappeared. He then felt well until Jan. 3, 1972, when he developed a pleural type pain in his right chest. He was examined by his surgeon on that day and no positive physical findings were noted. On the following day a pleural friction rub was heard and the patient subsequently had a chest x-ray (Figure 1). On Jan. 7, 1972, the patient was admitted to the hospital with the

(Continued)

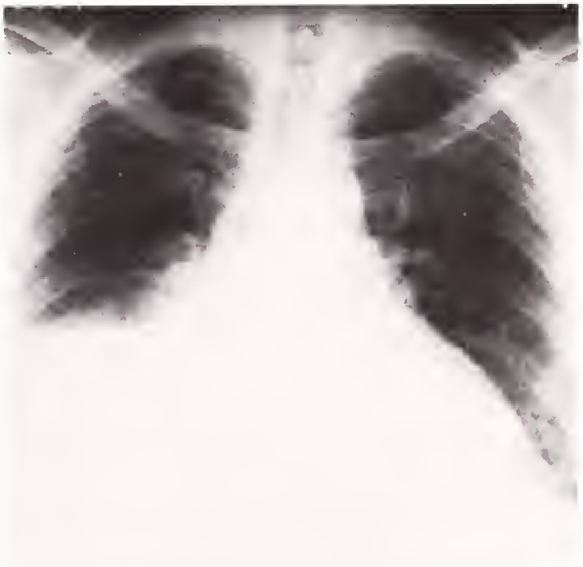

Figure 1. Chest x-ray film. Jan. 7, 1972. Consolidation of right lower lobe and infrapulmonary effusion.

Scientific articles

Doctor Alt, a specialist in internal medicine, is on the staffs of Hackley and Mercy Hospitals in Muskegon.

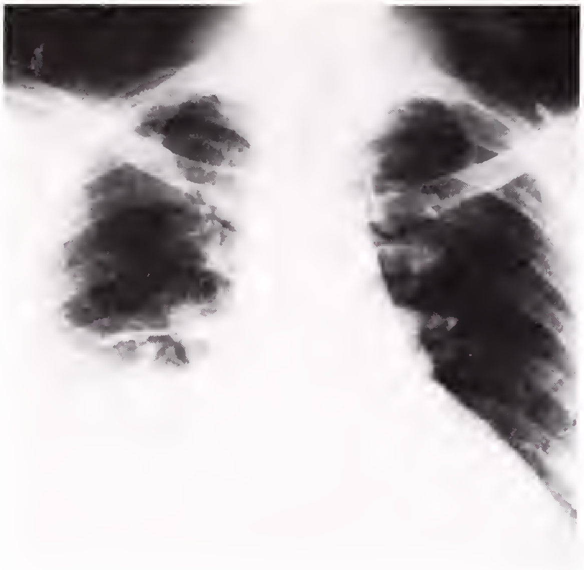

Figure 2. Chest x-ray film. Jan. 21, 1972. Partial clearing on right, infiltrate now present in the left lower lobe.

diagnosis of pneumonia. He did not have a chill or cough. Examination at that time showed blood pressure of 150/74, temperature, 102° F. There was dullness to percussion and marked decrease in breath sounds over the right lower lobe. Blood cultures were negative. Sputum cultures revealed normal flora. A right thoracentesis was done and 5cc of bloody, sterile fluid obtained. White count was 11,800, 80 percent segs. Laboratory data was otherwise normal. The patient became afebrile on Jan. 11, 1972. He was treated with Ampicillin ½ gram q. 6 h. The patient was discharged from the hospital Jan. 18, 1972, and he was asymptomatic at that time. He was readmitted to the hospital Jan. 21, 1972, stating that on Jan. 20, 1972, he had developed a chill and fever; in addition, he complained of discomfort in the calf of his left leg. While at home the patient had been doing leg exercises as he felt that would improve his physical condition. He also had noticed a pleural pain on the left. Physical examination at that time showed temperature of 102° F. He had dullness to percussion and decreased breath sounds over the right lower lobe, a pleural friction rub was present on the left. There was increased warmth of his left leg, (calf) as compared to the right. In addition he had a trace of pitting edema of the left leg and a positive Homan's sign on the left and calf tenderness. The remainder of the physical examination was negative.

Chest x-ray at this time revealed some infiltration at the left base (Figure 2). A lung scan revealed no further positive information. The patient was treated with Heparin and Coumadin and after one week the Heparin was discontinued. In addition he was treated with Ampicillin. The patient's recovery was uneventful and on Feb. 14, 1972, he returned to work on a full time basis, maintained on Coumadin alone. A repeat chest x-ray on March 6, 1972, revealed complete bilateral clearing except for minimal residual pleural thickening at the right base.

Comment

Other articles concerning side effects of vasectomy have discussed psychological aspects.[2-4] A failure (and regeneration) rate approaching 1 percent has been recognized.[5-8] Focal complications consisting of hematoma and infection have been described.[6,7,9] H. J. Roberts stated in a letter that he had seen ten patients with thrombophlebitis one to several years after vasectomy.[10] He did not document his statements. It is my belief that other precipitating factors probably entered the clinical situation, in his patients, over so lengthy an interval of time. In view of the case I report, the surgeon should provide ample time for his postoperative examinations, with particular reference to the possibilities of wound infection, hematoma and thrombophlebitis. Any vasectomy clinic has the same responsibility. The actual incidence of thrombophlebitis, following vasectomy, is unknown at this time.

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Hyperthyroidism presenting as acute shoulder pain

By Joseph J. Weiss, MD
George R. Thompson, MD, FACP
David Woodbury, MD
Eloise

Introduction

A little known feature of diffuse hyperthyroidism is its association with acute shoulder pain, this relationship was first pointed out by Duncan[1] in 1928. The next report in the American literature was not until 1952 when Skillern[2] evaluated 300 patients seen at the Cleveland Clinic with hyperthyroidism and found 20 who had "periarthritis" of one or both shoulders. In 1956 Chapman and Maloof,[3] in an article entitled "Bizarre Clinical Manifestations of Hyperthyroidism," presented nine cases including one in which "periarthritis" of the shoulder was the presenting complaint. In none of these papers was the mechanism of shoulder pain studied, though in Chapman and Maloof's case the patient had tendon calcification in the affected shoulder.

This paper presents the clinical manifestations and our investigations in three patients whose hyperthyroidism presented as disabling shoulder pain.

Results

The clinical features of these three patients are summarized in Table 1. There were two women and one man in our series; their ages ranged from 35 to 54 years. The patients presented to the outpatient department or emergency room because of acute shoulder pain, in one case right sided, in one left sided, in one instance with bilateral shoulder pain. At the same time the patients mentioned problems of weakness, increased nervousness, or recent weight loss. Palpation of the involved shoulder caused the patient diffuse pain; no pinpoint areas of hypersensitivity were present. Further physical examination revealed loss of 30-60° of abduction and 30° of external rotation. In addition all three patients had diffuse increase in the size of their thyroid gland and two of the three patients were noted to have a fine tremor of the hand.

Tests for anti-nuclear antibody (ANA) and C-reactive protein (CRP) were negative in all three patients; latex fixation was weakly reactive in two patients and negative in the other. Wintrobe sedimentation rates varied from 28-35 mm/hr. Serum uric acid ranged from 5.9 mg/100 cc-6.3 mg/100 cc. Serum calcium, phosphorus and alkaline phosphatase were within normal limits.

(Continued)

Table 1

Clinical Features of Three Patients with Shoulder Pain and Hyperthyroidism

Name	Sex	Age	Presenting Complaint	T_3 (N 22-36 percent)	24 hr RAI (N 10-35 percent)	X-ray	EMG
J G	Male	50	left shoulder pain	40.3	32 percent; 27 percent after cytomel suppression	Both shoulders within normal limits	left biceps, triceps and deltoid shortened motor units and diminished complexes
S.C.	Female	35	rt shoulder pain	55.9	88 percent	osteoporosis bilaterally	rt deltoid and supraspinatus. fibrillation waves, low amplitude and short duration motor units
W E.	Female	54	bilateral, esp left, shoulder pain	39.2	68 percent	osteoporosis bilaterally	not done

Table 2

Treatment Results in Three Patients with Hyperthyroidism Presenting with Shoulder Pain

Name	Initial Treatment	Result	I^{131}Treatment	Result
J G	A.S.A.;PT	No ⇩ in pain	2/71—8.0 mc I^{131}	4/71 marked ⇩ shoulder pain
S C.	A.S.A.; I-A steroids; phenylbutazone	± ⇩ in pain	1/70—8.0 mc I^{131}	3/70 ⇧ ROM; ⇩ pain
W E	A.S.A.; PT I-A steroids	No ⇩ in pain	7/69—6.5 mc I^{131}	9/69 gradual ⇧ ROM ⇩⇩ pain

A.S.A.—Acetylsalicylic acid
I-A—Intra-articular
PT—Physical therapy
ROM—Range of motion

The diagnosis of hyperthyroidism was substantiated by T_3 resin uptake (T_3) and radioactive iodine uptake studies (RAI). The patients' T_3 values ranged from 39.2 to 55.9 percent (normal 22-36 percent). The patient with the near normal value for T_3 had a 24 hour RAI uptake of 68.1 percent (normal 10-35 percent). One patient had an RAI uptake of 32 percent, in the upper range of normal. However, following the Cytomel suppression test, 75 micrograms of Cytomel orally for 7 days, repeat RAI was 27.7 percent, a value indicating nonsuppression of the thyroid gland and supporting the clinical diagnosis of hyperthyroidism.

Shoulder x-rays were normal except that two of the three patients had osteoporosis of the involved glenohumeral joint without similar changes elsewhere in the skeletal system. Soft tissue calcifications were specifically looked for, but were not present.

In two patients electromyographic studies (EMG) were undertaken. Myopathic units were present in the biceps, triceps and deltoid muscles of the involved shoulder. EMG findings in the thigh and hip girdle muscles did not show involvement as great as that found in the shoulder girdle musculature.

The response to treatment was similar in all three patients (Table 2). All received intensive therapy for their shoulder pain, but in no case was there any sustained response to aspirin, phenylbutazone, physical therapy or intra-articular steriod injection. Decrease in pain and reestablishment of normal joint function occurred only after the patients were treated for hyperthyroidism and were returned to the euthyroid state.

Discussion

Acute shoulder pain is usually related to bursitis, calcific tendinitis, osteoarthritis or rotator cuff tear. In rare instances the patient has idiopathic frozen shoulder or early rheumatoid arthritis.

Separation of hyperthyroidism from these other usual etiologies of shoulder pain is important for therapeutic reasons. Our experience confirms the report of Skillern:[2] the traditional therapies of heat, intra-articular joint injection and anti-inflammatory medication are of little value. Relief of shoulder pain occurs only after treatment for hyperthyroidism.

The basis for the relationship between hyperthyroidism and acute shoulder pain has not been explained. As already mentioned there is a single case report[3] in which calcific tendinitis of the shoulder cleared with successful treatment of hyperthyroidism. However no other series, either in the United States or Europe,[4] reporting on the association of hyperthyroidism with shoulder pain, has noted calcium deposition at the site of pain.

That there is some disorder in calcium metabolism seems likely. In two of our patients there was distinct osteoporosis in the affected shoulder. While this osteoporosis can represent the result of disease rather than its pathogenesis, such does not appear to be the case in these patients. In

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This paper is from the Department of Internal Medicine, Division of Rheumatology and Endocrinology, Wayne County General Hospital, Eloise, and was presented in part at the Michigan regional meeting of the American College of Physicians, Sept. 22, 1972, in Gaylord.

all three of our patients the onset of pain was sudden, and each patient had x-rays within one or two days of the initiation of their shoulder problem—too soon for the changes of disuse osteoporosis.

Moreover, the effect of hyperthyroidism on bone metabolism has long been appreciated. In 1891 Von Reclinghausen[5] reported on the occurrence of osteitis fibrosa cystica in women with toxic diffuse goiter. Follis[6] in 1953 studied the vertebrae of 20 patients with hyperthyroidism who came to autopsy; all 20 showed evidence of osteomalacia and osteoporosis. In 1967 Adams[7] and his associates, using ingested tetracycline and microradiographic techniques, confirmed that reabsorption of bone occurred in hyperthyroid patients.

The existence of muscular weakness in hyperthyroidism, especially in the hip and shoulder girdle, is also well known.[8] EMG findings, as typified by our cases, consist of reduced duration of action potentials and increased number of polyphasic units. A point generally not appreciated but emphasized by Adams and Rosnan,[8] is that muscular involvement need not affect shoulder and hip muscles equally. In our patients the disparity was particularly prominent, with shoulder girdle involvement being greater than hip girdle involvement, and one shoulder affected more than the other.

One other aspect of hyperthyroidism needs emphasis if we are to explain the joint pain present in our patients. Hydroxproline excretion is increased in hyperthyroidism. It has been assumed that collagen degradation, which is the source of the hydroxproline, originates in the connective tissue matrix in bone. However, Kivirikko and his associates[9] have demonstrated increased catabolism of body collagen in hyperthyroidism produced in animal models. It is reasonable to suspect that the increased collagen degradation occurring in human hyperthyroidism includes not only bone but other collagen containing tissues such as skin and ligaments.

This effect on ligaments is of particular importance for the shoulder joint. As *Figure 1* illustrates, the integrity of the joint is dependent upon the three glenohumeral ligaments which hold the humeral head anteriorly within the glenoid fossa. Weakness of these ligaments will result in undue stretch upon the anterior joint capsule.

We can now explain why our patients with hyperthyroidism developed shoulder joint pain: myopathy involving the deltoids and rotator cuff muscles led to increased strain upon the connective tissue elements of the glenohumeral joint capsule; osteoporosis of the shoulder joint further weakened the insertion of these tissues. This strain was aggravated by degradation of the ligaments from a primary action of thyroid hormone. Thus in selected cases, thyroid induced bone, muscle and ligament weakness produces undue stretch upon the joint capsule and causes acute shoulder pain in patients with untreated hyperthyroidism.

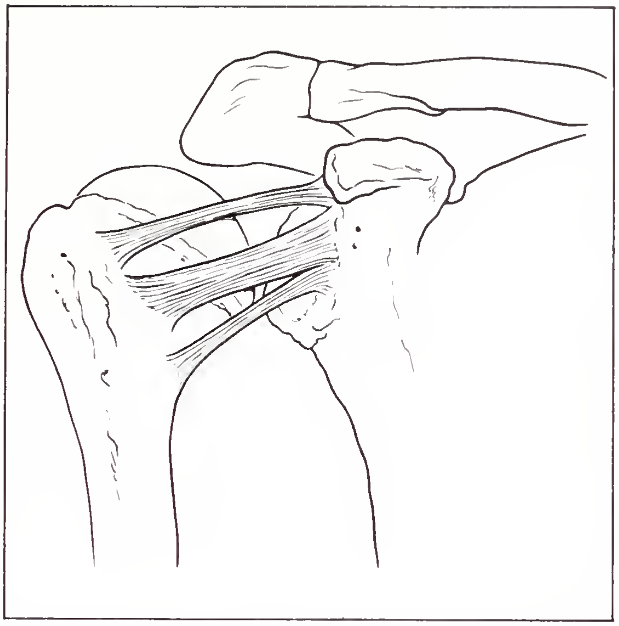

Figure 1: Anatomy of the glenohumeral joint. Note that the integrity of shoulder joint capsule depends on the insertion of the three glenohumeral ligaments between the humeral head and the anterior glenoid surface.

Summary

We have studied three patients with hyperthyroidism who presented with shoulder pain. Therapy with aspirin, heat and analgesics was ineffective. Remission of shoulder pain occurred only when the patient was treated for hyperthyroidism. The pain appeared due to excessive stretch on the glenohumeral ligaments secondary to the action of thyroid hormone on the osseous, ligamentous and muscular components of the shoulder joint.

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(Continued)

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

MONTHLY SURVEILLANCE REPORT

CASES OF CERTAIN DISEASES
REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH
For the four-week period ending Sept. 28, 1973

	1973 This 4-Week Period	1972 Same 4-Week Period	1973 Total To Above Date	1972 Total Same Date	Total Cases for 1972
Rubella	26	17	1,849	1,280	1,460
Cong. Rubella Syndrome	0	0	1	0	1
Measles	25	17	4,378	1,993	2,353
Whooping Cough	11	6	58	81	116
Diphtheria	0	0	0	1	1
Mumps	59	47	3,952	2,740	3,729
Scarlet Fever & Strep Sore Throat	915	453	16,200	8,517	13,304
Tetanus	0	0	1	1	2
Poliomyelitis (paralytic)	0	0	0	0	1
Hepatitis	289	335	2,895	3,223	4,322
Salmonellosis (other than S. typhi)	82	70	544	618	781
Typhoid Fever (S. typhi)	2	0	10	6	7
Shigellosis	41	51	448	443	574
Aseptic Meningitis	81	50	314	151	266
Encephalitis	14	8	129	72	108
Meningococcic Meningitis	2	1	41	40	55
H. Influenza Meningitis	1	4	71	59	81
Tuberculosis	107	108	1,083	1,267	1,609
Syphilis	296	271	3,216*	3,627	4,815
Gonorrhea	2,715	2,118	22,449*	17,834	24,728

Information can be supplied by the local health department on the local incidence of disease.

*corrected totals

Maurice Reizen, MD, Director
Michigan Department of Public Health

HYPERTHYROIDISM/Continued

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Special TV series opens Nov. 19

Early detection and treatment of the five medical conditions that account for three of every four deaths in the United States will be the focus in a new series of five television programs to be presented by Public Television stations across the country, beginning Nov. 19. The programs are to be shown from 8 to 9:30 o'clock every fourth Monday evening through March 11.

The dates and subjects are: Nov. 19, *Heart Disease;* Dec. 17, *Inborn Genetic Defects;* Jan. 14, *Pulmonary Disease;* Feb. 11, *Trauma,* and March 11, *Cancer.*

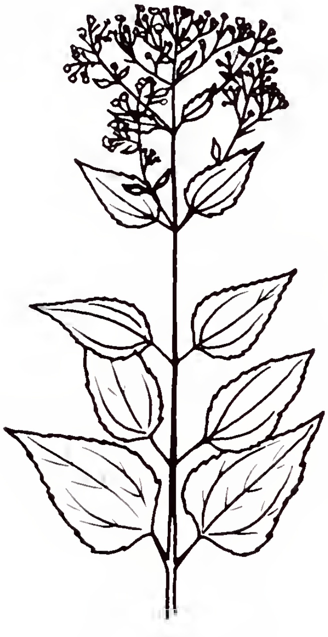
Michigan stations scheduled to carry the programs are:

WTVS-Ch 56 Detroit
WKAR-Ch 23 East Lansing
WGVC-Ch 35 Grand Rapids
WNMR-Ch 13 Marquette
WCMU-Ch 14 Mount Pleasant
WUCM-Ch 19 University Center

Some of the stations plan to schedule local programming to supplement the specials.

MILK SICKNESS: A disease of the Middle West

By George E. McKeever, MD
Dearborn



White Snakeroot

Milk sickness has vanished from the list of major concerns of modern Americans. In a cycle of two centuries a disease threat materialized, was contained and finally was returned to the status of a threat. Milk sickness wrought epidemic havoc in the Middle West (the Old Northwest). It constituted, in some years and some localities, the number one obstacle to settlement. The epidemic of milk sickness was conquered by the ingenuity of the pioneer American farmer. The threat of the disease has persisted up to the present time. The main theme of this paper is to view the milk sickness as a setpiece of a problem faced by man. One question raised by this inquiry remains: Why does a problem persist when its solution has been found?

Recognition of the Problem

The year 1815 closed the era of the Napoleonic wars and opened a century of relative peace in Europe. The Treaty of Ghent formally ended the American counterpart of those wars in 1815. Now, "the American people were able for the first time since their nation's establishment to devote their major energies to domestic rather than foreign problems."[1] The western frontier had been involved in the ferment of war from 1812 to 1815, creating a barrier to western migration. When this barrier was removed by the above treaty, a flood of pioneers moved west. The settlers were destined to meet many challenges; none would be more formidable than the milk sickness.

There is some evidence that cases of milk sickness had occurred at the time of the American Revolution in the mountainous areas of western North Carolina. One of the mountain peaks there bears the name "Milksick."[2] This disease occurs in humans following ingestion of a certain poison. This poison is now known to be a natural constituent of the plant white snakeroot. Cattle feeding on this plant ingest the poison and develop a disease called "trembles," named after the most obvious symptom. Humans ingest the poison contained in the milk or flesh of a poisoned animal. The conditions necessary for this chain of events to occur were present in the Middle West. First, the plant containing the poison grew there. The second condition was fulfilled by the arrival of a population made susceptible to ingestion of the poison by a culture based on animal husbandry. People sickened and died, cause unknown. The numbers increased. In time a pattern was discerned. The first striking human symptom is severe vomiting; hence the early name, "sick stomach." The cause remained unknown. This was in keeping with the early nineteenth century when the causes of most diseases remained mysterious.

Definition of the Problem

The name, "sick stomach," described the symptoms of nausea and vomiting, but also suggested an association with something ingested. Continued observation soon pointed to milk as the offending ingestant. The new name, "milk sickness," capped this new and valuable knowledge. Now, the problem had been recognized and identified by the farmers. A simple, direct method of prevention

(Continued)

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was obvious: avoid milk. This prohibition was effective but worked a hardship on those who lived by animal husbandry.*

Hardship notwithstanding, abstinence from milk was practiced in some areas over a long period of time. All, however, did not abstain. Some were skeptical of the new intelligence; others were newcomers who were ignorant of the danger. The disease continued to occur in endemic numbers. Epidemics of the disease occurred among the ignorant and skeptical. Variations in the amount of poisonous snakeroot ingested by the cattle determined the variations in the frequency and severity of the disease.

The name, milk sickness, indicates that the farmer had traced the disease to his milk cows. It has long been known that the quality of milk and butter can be altered by the forage of the milk cows. Leeks eaten by cows result in "leeky" butter, which has a distinctive unpleasant taste. Continued farmer observation related the disease, milk sickness, in humans, to a bovine disease, trembles. These two diseases occurred only in late summer and fall.

The farmer observer now directed his attention to the milk cows and particularly to the cows' forage. They noted that the trembles occurred only when the cows were allowed to feed in certain wooded areas and also in certain "wild" pastures. Now, the disease could be controlled by excluding cattle from these areas.

Control by exclusion was not always practiced for many reasons. Among these are ignorance, skepticism, false theories as to the cause of trembles, lack of other forage and accidental escape of cattle into the poisonous areas. Because of these reasons, man was obliged to protect himself from milk sickness by additional safeguards. Milk of uncertain quality could be tested on a cat, which would sicken in a few hours. Recognition of a poisoned cow was often impossible due to a peculiarity of mammalian metabolism; the poison ingested by the cow is excreted in the milk, protecting the cow but poisoning the calf and other milk consumers.

The farmer thus learned to watch the steers for the first sign of the disease, trembles. The poisoned steer would sicken, tremble and die. A latent case would be made manifest by forcing the animal to muscular exertion.

The farmer soon learned that he could not eat the flesh of an animal dead of the trembles nor could he feed the carcass to dogs or hogs. He had learned the poison was present in the flesh as well as the milk. Another safeguard was instituted to prevent human poisoning: drive the cattle before purchase or slaughter to detect latent trembles. This challenge of exercise forced latent cases of trembles to become clinically manifest. Thus, the exercise tolerance test served as a quality control for beef animals as well as for milk producers.

After milk sickness had been recognized, named and described, with the description including a synchrony with, and causal relation to, the disease of cattle, trembles, a method of preventing the trembles in cattle by enclosure plus additional safeguards (quality control) against milk sickness became a part of the midwest farmer culture based on animal husbandry. Continued research sought to discover the poisonous agent known to occur in wet forests and in "wild" pastures. Knowledge sufficient to prevent milk sickness and trembles was already available, but it was not common nor universally accepted.

The goals of continued search were (1) to extend the usefulness of the land, (2) to provide additional safeguards against accidental poisoning, (3) to satisfy a natural curiosity about or scientific interest in one of the ever-present hazards to life. Continued observation showed that the poisonings occurred only in the summer and fall, pointing to a plant. All plants in the poison areas were naturally suspect. Two plants were more suspect than others. They were (1) *Rhus toxicodendron,* poison ivy, (2) white snakeroot *Eupatorium urticaefolium.*[3]

In the second quarter of the nineteenth century the time had come for feeding experiments. There is reason to believe that many farmers experimented in this way and actually confirmed their suspicions in the case of white snakeroot. The momentous discovery solved the mystery of the poisonous cause of milk sickness. Failure to communicate and skepticism caused the discovery to be stillborn. Our best known example of the farmer-experimenter was John Rowe, a farmer of Fayette County, Ohio. He announced the results of his experiments and his conclusions in one of the newspapers of the town of Washington Court House, Ohio. The fruit of this experiment was spoiled by the skepticism of the most famous physician of the Middle West, Doctor Daniel Drake.[4]

Systematic Study

In 1841 Doctor Drake published the results of his survey on milk sickness conducted during the preceding fall.

The knowledge of the problem of milk sickness had been earned by observation and trial-and-error. The knowledge was at the level of folklore, which is often needful of skeptical analysis. Escalation of understanding of the disease demanded a scientific approach. This required a higher level of education, skill, training and experience: the educated, professional physician. The scientist would have to be an exceptional person possessed of a special interest in the problem and of sufficient uncommitted time to spend in study of the problem.

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*This solution would be analogous to solving our twentieth-century problem—of highway fatalities—by discontinuing the use of automobiles.

Nosology was rudimentary and primitive in that era. In areas where milk sickness was common, patients suffering from other ailments were mistakenly diagnosed as having milk sickness. Typhoid fever and malaria were common in the same season, but were distinguished by fever. One can easily picture the confusion produced by the fact that most of the people in the area were victims of malaria as a chronic burden. Milk sickness and other afflictions were layered on creating a higher level of suffering for the patient and a dilemma for the doctor. In areas where milk sickness was uncommon, the patient would be mistakenly diagnosed as suffering from some other disease, such as food poisoning.

Further confusion developed because the problem was completely ignored by the medical hierarchy of the East. John Eberle's **Practice of Medicine** (1841) contains no mention of milk sickness.[5] He was professor of materia medica and botany in the Ohio Medical College. This would place him in Cincinnati, in the heart of the milk sickness country, at a college founded by Daniel Drake. This omission is equivalent to denial of the existence of a problem.

Daniel Drake determined to cut through the web of confusion by means of a scientific study of milk sickness in a limited area. On horseback and on foot, Drake studied four counties in Ohio between Columbus and Dayton from September 1 to 15, 1840. Ironically, Drake encountered no cases of milk sickness or trembles. He observed the geology and flora of the area. He also interviewed most of the physicians and many of the farmers, including Rowe. Drake presented his paper to the medical convention of Kentucky; he was a professor at the Medical Institute of Louisville at the time. The paper was published as well. His opening paragraph is quoted:

> *It is generally known, that on the western side of the Allegheny mountains, from Georgia to the Lakes, a disorder, called Trembles, has for a long time prevailed among cattle and other domestic animals; and that wherever it has appeared, the people have been liable to a disease, which from its prominent symptom has received the name of Sick Stomach, and from a hypothesis concerning its cause, that of Milk Sickness. These maladies, which may be regarded as endemics of the central portions of the Mississippi Valley, have not shown themselves equally in all parts of it—as large districts are known to be entirely exempt.*[6]

Drake's writings had a style and content which made him one of the outstanding literary figures of the Cincinnati school of writers. This school was the first concentration of writers in the Midwest.[7] Drake criticized the findings of Rowe, particularly because of Rowe's superficial knowledge of botany.

Actually, Doctor Drake and Farmer Rowe were in agreement down to a variance on which of two wet-forest plants contained the poison. Drake favored poison ivy on theoretical grounds. Rowe was in fact a few steps ahead of the professor by virtue of published feeding experiments. True science involves a wedding of *Theorea* (theory of Doctor Drake) to *Technè* (practical experiments of Farmer Rowe). A modern scientific treatment had to wait until the twentieth century and Edwin Lincoln Mosely.[8]

In summary, Drake systematized and organized the knowledge available at a folk level. He added nothing but an opinion as to the exact plant; and this guess has since proved to be erroneous. The intelligence regarding the disease became formalized and static. Fifty-two years later, Osler had this to say:

> *This remarkable disease prevails in certain districts of the United States, west of the Allegheny Mountains, and is connected with the affection in cattle known as the trembles. It prevailed extensively in the early settlements in certain of the Western States and proved very fatal. The general opinion is that it is communicated to man only by eating the flesh or drinking the milk of diseased animals . . . . Nothing definite is known as to the cause of the disease. It is most frequent in new settlements. . . . Fortunately, the disease has become rare, and the observation of Drake, Yandell and others that the disease gradually disappears with the clearing of the forests and improved tillage has been amply substantiated. It still prevails in parts of North Carolina.*[9]

Note that one-half century later, the most famous physician of the English-speaking world merely restates the folk knowledge. Moreover, he remains a step behind Farmer Rowe.

General Acceptance of Specific Cause

In the 1880s a medical revolution was occurring following the discoveries in the field of bacteriology by Pasteur in France and Koch in Germany. Alphonse Laveran, a French army surgeon, discovered the protozoan cause of malaria in 1880. The name "malaria" came from the belief that the

(Continued)

disease was due to "bad air" or "miasmas" that arise from swamps. This was actually pretty close since mosquitoes are in such air. There were some people who thought that milk sickness had the same cause; i.e., bad air from moist places. Since there had been no definite identification of one specific plant cause, confidence in the knowledge was insecure. Meanwhile, the disease had become rare through the use of safeguards. The only cases at this time were the result of willful or accidental violation of the well-known precautions. As more and more diseases revealed their causes to be bacterial, protozoan or helminthic parasites, the expectation developed that all obscurely caused ailments would prove to be similarly produced. This expectation appeared to have been realized in 1908 when Jordan and Harris reported a bacterial cause for milk sickness and trembles. Jordan was the professor of bacteriology at the University of Chicago. The discovery proved to be spurious, but they did supply another piece to the puzzle. The disease in a new area could not be due to either of the two most suspected plants for the simple reason that they do not grow in the southwest. We quote the report:

> *New focus of milksickness: In November, 1907, we discovered a new focus of milksickness in the valley of the Pecos River, New Mexico, nearly 1,000 miles distant from the region where the disease had previously been known to prevail. At the time of our visit to the Pecos Valley the death of stock from this cause was generally attributed to "alkali poisoning." Some local observers, however, held the view that the trouble was due to the cattle eating some poisonous plant, the rayless goldenrod (Bigelovia rusbyi) being the plant most commonly suspected.*[10]

So far, the scientists were still working at a level of intelligence below the folk level which had recognized white snakeroot in the midwest and the rayless goldenrod in the southwest.

Something of a change can be followed in clinical case reports of milk sickness. Walsh reported a series of cases over a period of time:

> *In 1902, three members of a family near Morris had been sick for about two weeks, with loss of appetite, general weakness and slight pains in the region of the stomach. One of the group, the hired man, had apparently recovered completely. He walked four miles to see a physician, walked home and went to bed. He died in coma the next day. The employer, who had been sick and had recovered, assisted with the funeral and died in three days. The diagnosis was "milk sick," of which nothing was known. The late Doctor Bertram Sippy was called, and we obtained specimens of blood, sputum, urine and feces while the man was alive. Rabbits and guinea-pigs were injected and cultures made.*[11]

Note that the reference to milk sickness as a disease of which nothing was known is pure "Osler." This represents a distracting allegiance to an eastern professor by a midwest physician. From the last sentence we can see that they were searching for an infectious organism.

Six years later Walsh treated another family:

> *The second day after the death of the little girl, her mother was taken violently sick with vomiting, extreme prostration, pain in the abdomen, constipation, headache, subnormal temperature and fast pulse. The diacetic acid and acetone found in the case of the little girl suggested that we were dealing with a condition of severe acidosis. Diacetic acid was found in the mother's urine. In accordance with the usual treatment of acidosis at that time, we gave a teaspoonful of sodium bicarbonate by mouth every hour and 2 ounces by rectum every six hours. She made a complete recovery. This was the first case of milk sick which was treated in this way.*[12]

Doctor Walsh had become more sophisticated after the passage of six years. Milk sickness was noted for the first time to be characterized by an acidosis.

The change that was occurring in the twentieth century was the emergence of a truly scientific approach to the problem of milk sickness. A large amount of scientific research on the white snakeroot was carried on by Edwin Lincoln Moseley,* professor of biology, State University, Bowling Green, Ohio. He began a 30-year series of feeding experiments in 1905. In addition to his purely scientific interest, Moseley was a student of the history of the milk sickness problem. His book is the definitive work on the subject of milk sickness. His comment on the treatment of patients is sobering:

> *In the light of our present knowledge of medicines we are inclined to think that most of those which were administered in treating this disease did little or no good and that many of them hastened the death of the patient. It is probable that a large number of milk-sick persons who soon succumbed to the drastic drugs they were compelled to swallow would have eventually recovered if no medicine had been given them.*[13]

Moseley also cites some work from the east which obscured the truth by erroneous interpretation:

> *Experiments in feeding white snakeroot or*

**The middle name suggests a possible attraction to this subject by the fact that the most famous victim of milk sickness was Abraham Lincoln's mother, Nancy Hanks Lincoln.*

> *preparations made from it were undertaken in 1908 by A. C. Crawford of the Bureau of Plant Industry, Washington, D.C. and others . . . . All, except A. C. Crawford, found the plant to produce the same symptoms as are manifested by animals which have contracted the disease in the woods. It is unfortunate that Crawford, who worked with aqueous extracts of plants sent to Washington from Illinois, reported differently from other experimenters, for his report, emanating, as it did, from the U.S. Department of Agriculture, caused years of delay in the general acceptance of the very important fact that Trembles and Milk Sickness, throughout the large region with which we have been dealing, is due to the stock eating white snakeroot.*[14]

Finally, Couch presented the active agent of the white snakeroot that produces the disease milk sickness.[15] The same substance, a secondary alcohol called tremetol, has been found in the rayless goldenrod; thus explaining the occurrence of the disease in the southwest. This is the last increment in our knowledge and brings us to the modern period.

The Modern Period

The modern period of the milk sick problem finds us more secure in our knowledge of the cause, the pathophysiology, and the appropriate treatment. Case reports are rare. When a disease becomes rare, it is more likely that it will be misdiagnosed. Hartman reported treating a case of severe acidosis in a seven month old baby. The year was 1962:

> *The patient now seemed to have recovered fully, but from what? The key to the situation seemed to be the intense and persistent ketosis, not accounted for by diabetes, and poorly responsive to administration of antiketogenic substance. We knew of only one condition other than salicylate intoxication that seemed a possible reason—that of snakeroot or tremetol poisoning, so we thought best that I should talk with the mother about the infant's diet. What she told me was most gratifying. The family lived in the country, and the father was enthusiastic about the virtues of raw milk. Such milk was obtained from a nearby farmer and fed to the entire family, including father, mother, a 20 month old sister of the patient and "occasionally" to the patient. I was familiar with the neighborhood and knew that snakeroot abounded in the vicinity; later inspection of the farm revealed the presence of snakeroot in abundance, to which the small dairy herd had access. The possibility of tremetol poisoning then seemed real.*[16]

Later, Hartman commented:

> *It is certain that the possibility of tremetol poisoning would not have occurred to me had I not remembered one previous, similar case seen in 1946. This patient was an older child, from across the Mississippi River in Illinois, drinking raw milk from a poisoned cow. Snakeroot poisoning developed in the typical manner.*[17]

Hartman then relates how he had diagnosed the case of 1946:

> *The family milk and butter supply was from their own cows. Snakeroot (called snakeweed by the father) was known to be abundant in the vicinity, cattle of neighbors were known to suffer from trembles from time to time and some years previously several members of a neighboring family were studied in Barnes Hospital because of milk sickness thought to be due to snakeroot poisoning. The father was therefore familiar with the disease, and when he brought the patient to the hospital he suggested that she might be suffering from it . . . .*[18]

The medical center physician made his diagnosis following the suggestion of the farmer. This is, of course, the same folk knowledge possessed by the pioneers. It has been repeatedly suggested that many cases are missed. Such is the nature of poisonings. The history is the most important basis for a diagnosis. Unless the doctor is as alert to the significance of the history, as was Doctor Hartman, there is no way the diagnosis could be made.

In summary, we have traced a problem faced by man in his settlement and development of a new area, the American Midwest. The problem was recognized as a threat to health, defined, and contained by the application of the native intelligence of the American farmer. Early professional attempts at scientific analysis and solution miscarried and retarded advancement of knowledge. Careful and competent scientific experimentation and reflection by more capable and careful scientists were fruitful in confirming the folk knowledge of poisoning by the white snakeroot. It must be conceded that remarkably little has been added to the fund of knowledge of the problem of milk sickness by modern science. Does this study in the natural history of a kind of poisoning have any lesson for the "Jet Age?" Yes. The chief lesson is that poisoning is very difficult to detect, to prove and to prevent. Care should be exercised in such things as food and water additives designed to "improve quality." We blithely add fluoride to water and iodine to salt. These are highly-reactive elements. Do we really know that they are not harmful? Government reassurances are little comfort when we recall that A. C. Crawford, of the Bureau of Plant Industry, Washington, D.C., was

(Continued)

so confident in his conclusion of the harmlessness of white snakeroot that he fed it to himself. He was saved from his own ignorance by an undercalculation of the dose.[19]

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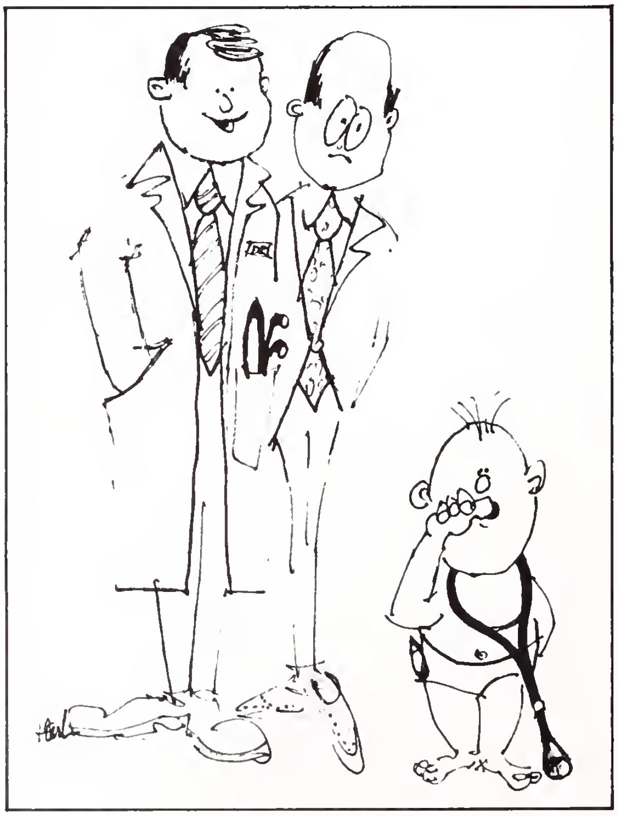

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Perinatal tips

By Paul Zavell, MD
Detroit

The following case from the files of the Wayne County Medical Society Perinatal Mortality Study Committee is presented as an aid in continuing education.

Maternal

This was the fourth pregnancy for this 32-year-old, B+ white mother. Her first two pregnancies ended in spontaneous abortions at 3 and 3½ months respectively. Her third pregnancy was terminated by the birth of a live term female infant who at 2 years of age is home and well.

This pregnancy was uneventful. The mother had received routine prenatal care and she gained a total of 13 pounds. Four days before delivery her membranes ruptured spontaneously and she continued to have a slow intermittent vaginal drip of amniotic fluid until the day of delivery when labor pains began. She then called her general practitioner who had her immediately admitted to the hospital. Shortly before birth the delivering general practitioner first learned of the prolonged rupture of the patient's membranes. He did a vaginal smear on some amniotic fluid that revealed gram positive cocci. Nine hours and five minutes later her first living son was born. The mother's post-natal course was uneventful. Studies done in the hospital were: Hgb. of 13.2 gm, Hct of 40, HAI test neg., VDRL test neg. During labor the mother received 50 mgm Demerol and 1/120 Scopalamine 3 hours before delivery. She received a total of 1500 cc of 5 percent D/W with one ampule of Pitocin added during the course of her labor.

Fetal

This 6 pound 7½ ounce white male infant was slow to breathe and appeared pale. However, after nasal and gastric suction and being placed in oxygen in an incubator, he seemed to do well. No Apgar scores are recorded. After finishing with the mother in the delivery room the general practitioner went to the newborn nursery and did a physical exam on the infant. He felt all was well but the infant looked a little pale. No orders but "routine" suctioning p.r.n., O_2p.r.n. and starting on glucose water q 4 hours at 4 hours of age were left. The infant spent the next 16 hours in the incubator with 1-2 liter per minute of oxygen continuously. The following morning the general practitioner reexamined the baby. He noted the infant was quite pale and was told he was sucking very poorly. A CBC was done revealing a hemoglobin of 5.9 gm and Hct of 16.5 percent with 31,250 WBC's and a smear of 6 Bds, 62 Segs, 1 Eos, 27 lymphocytes and 11 nucleated RBC's/100 WBC's.

A pediatrician was then called into consultation. He saw the infant shortly after being notified. Physical exam confirmed the earlier findings with respiratory rate of 40/minute and heart rate of 140 and no murmur. The diagnosis was "sepsis in the newborn with secondary anemia." The hemoglobin was repeated quickly and found to be 5.9 gm. Cultures of blood, throat, axilla, gastric contents and umbilicus but not of the CNS were done. The infant was then given 30 cc's of packed

(Continued)

Doctor Zavell is chairman, Perinatal Mortality Study Committee, Wayne County Medical Society, and a member of the Neo-Natal and Hospital Care Committee, Michigan Chapter, American Academy of Physicians.

O+ RBC's. Kantrex 22 mgm q 12 h I.M. and Penicillin G 150,000 U q 12 h IV as well as 5 percent G/W in 0.2 NS via umbilical vein were started. The following day a repeat hemoglobin was only 7.7 gm with 43.5 percent Hct. The infant was given another 25 cc of O+ packed RBC's. By the third day of life, cultures were reported back showing staphylococcus albus of axilla, alpha streptococcus of the gastric contents and diplococcus pneumonia of the throat and blood. The treatment of Penicillin and Kantrex was felt adequate and was continued. At this time the hemoglobin was reported as 11.0 gm with Hct of 35 percent. The infant had remained afebrile and was suctioning well so that by the 4th day of life oxygen and I.V.'s were stopped and he was transferred to a crib. The Hemoglobin was now 12.3 gm and Hct of 38 percent. The infant's course seemed uneventful thereafter. On the 8th day of life both Penicillin and Kantrex were stopped. Within 24 hours however, the temperature rose to 101° and the infant seemed irritable. Throat and urine cultures were taken and he was placed back on Penicillin and Kantrex. Both cultures subsequently showed E. Coli so that Penicillin but not Kantrex was stopped. No G.U. studies were done except for a BUN which was 11.5. At 16 days of life repeat throat and urine cultures were negative but the hemoglobin was now 9.8 gm. Kantrex was now stopped. Over the next 4 days the infant remained afebrile and he received daily injections of 1.0 cc Imferon before discharge home on Similac with iron on the 20th day of life. Final diagnoses were "Term birth living white male infant with pneumococcal sepsis, anemia secondary to the sepsis and acquired E. Coli pharyngitis."

Perinatal Committee Comments:

1. OB patients should be instructed to call their doctor whenever anything unusual or out of the way seems to occur in their pregnancy (such as possible ruptured membranes, prolonged cessation of fetal movements, etc.).
2. Culture of amniotic fluid where possible when prolonged rupture of membranes has occurred may be helpful to the doctor managing the infant.
3. A vaginal smear can be very useful in a complicated case such as this especially if unusual organisms (i.e. gram negative rods) are found.
4. In a questionable case the obstetrician should try to preserve the placenta for 24-48 hours (by refrigeration) and if the pediatrician then feels it useful the placenta should be sent to the MSMS Placental Registry for evaluation and study.
5. The committee felt that when it is necessary to give the infant a blood transfusion it is wise to first draw sufficient blood from the infant for any and all hematologic studies that may be needed later.
6. Although there is disagreement at present in pediatric circles concerning the kinds and types of culture to be obtained from the infant there still is little substitute for blood, CNS and ear cultures. This case shows the confusion about which bacteria is really important that can result from doing too many cultures. Gastric content analysis by smear can be very helpful in deciding if infection is present since more than 10 WBC seems to correlate well with infection in the infant.
7. When sepsis is suspected (or proven) antibiotics should be given for 10-14 days and not 5-6 days as was the case here.
8. When an infant is irritable without adequate explanation an L.P. with culture should be done.
9. A BUN alone in evaluation of a positive urine culture is not usually sufficient. Rather a suprapubic tap for culture and I.V.P. should be seriously considered.
10. Among other possible diagnoses that could have been considered were fetal to maternal transfusion and hemolytic disease.

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Brock E. Brush, MD (right), steps toward the House of Delegates podium after his selection as MSMS president-elect. Brooker L. Masters, MD, newly installed president, provides an escort.

Annual Session Report

BROCK E. BRUSH, MD, OF DEARBORN, who on Oct. 9 was named president-elect of the Michigan State Medical Society, is a Canadian who came to Michigan for his internship and a surgical residency and decided to stay. A graduate of the medical school of the University of Western Ontario in London, Doctor Brush has been affiliated with Henry Ford Hospital, where he is a surgical division chief, since 1938. A fellow of the American College of Surgeons and a diplomate of the American Board of Surgery, Doctor Brush is a past president of the Detroit Academy of Surgery and the Detroit Surgical Association. He has shared his knowledge in the publication of 70 scientific papers on clinical and experimental research problems. Until stepping into his new role as president-elect, Doctor Brush served as MSMS Council vice-chairman. He continues in the chairmanship of the Education Liaison Committee.

Vernon V. Bass, MD, of Saginaw, who was reelected speaker of the MSMS House of Delegates, presides over 1973 Annual Session in Detroit's Sheraton-Cadillac Hotel.

Practice politics as well as medicine, physicians told

The impact of public policy upon the medical profession illuminates the need for health professionals to become involved in the decision making, Michigan physicians were told Oct. 8 by a family doctor turned governor.

Gov. Otis R. Bowen of Indiana, who makes certain that the "MD" after his name appears on highway signs and official documents, called on physicians to be "effective and understanding practitioners of the political as well as the healing arts" as he addressed the annual luncheon meeting of the Michigan Doctors Political Action Committee. The event was held during the medical society's 1973 Annual Session in Detroit.

"The argument has long been lost as to whether government will become increasingly involved in America's health care delivery system; and in fact centers truly upon the direction and degree that government's involvement will take," Gov. Bowen said.

"We have perhaps increased the public's health care expectations beyond our present delivery capabilities because of shortage of physicians, the maldistribution of those physicians which we do train, and the necessary differentiation of health care staffing specialties which has kept pace neither with actual scientific advancements nor with the public's perception of the state of medical art. Perhaps we, as a profession, have been too slow to evolve in our own practices.

"Perhaps the rapidly changing social patterns and population shifts from rural to urban, from urban to suburban and from the family doctor concept to one of massive specialization are largely responsible for the evident disparity between service expected and service delivered.

"It quite possibly was never realistic for the medical profession to hold out hope that our health care delivery system would not become increasingly impacted by governmental action; for the trend to seek public solutions to human problems has quite obviously been accelerating over the course of modern history.

"What I believe our professional role should be is to be increasingly aware, and understanding, of the causal motivations which give impetus to increasing public involvement in health care delivery. The public is keenly aware of the potential of a smoothly functioning system of health care delivery—and it desires that the full scope of those services be reasonably accessible to all.

"Perhaps our professional concern for the ultimate direction of American health care actually has its roots in economic soil . . . the spiraling costs of building construction and living . . . the increasing expense of both medical education and medical research, to name a few possibilities.

"But whatever the actual reason for the increasing pressure for government's growing presence within our health care delivery system, our approach should be one based upon expanding the humane practice of medicine as broadly and as reasonably priced as is humanly possible."

Gov. Bowen urged physicians to approach problems of health care delivery as they approach medical problems: diagnosis followed by compassionate treatment.

A special guest at the MDPAC luncheon, along with Doctor Bowen, was W. J. Lewis, MD, of Dayton, Ohio, chairman of the AMPAC board of directors. He told physicians that in a democracy politics is "not an elective but a required course."

Doctor Lewis urged, "Don't let anything keep you from being an active participant in the process that makes this country run."

Otis R. Bowen, MD, governor of Indiana (left) was all smiles as he arrived at the Sheraton-Cadillac Hotel in Detroit for an address Oct. 8 at the annual luncheon of the Michigan Doctors Political Action Committee. And one of the reasons for the doctor-governor's geniality was a reunion with Brooker L. Masters, MD, who was installed the same day as MSMS president. The two were classmates at the Indiana University School of Medicine.

Reference committee deliberations on resolutions dealing with medical education were of high interest to delegates during the 1973 MSMS Annual Session. Committee members intent on discussion are (above, left to right) Marjorie Peebles Meyers, MD, of Detroit; Kenneth J. Ray, MD, of Grosse Ile; Thomas C. Payne, MD, of Lansing; Richard H. Gascoigne, MD, of Adrian, chairman, and Gerald H. Mandell, MD, of Detroit.

1973 Annual Session

Cecelia Hissong, MD, of Dearborn, delegate from Wayne County, and R. William Holden, third year student at the Wayne State University School of Medicine, discuss the question before the House. Doctor Hissong is president-elect of the Michigan Academy of Family Physicians.

Robert J. Toteff, MD, of Saginaw, describes MSMS efforts to increase the number of primary care physicians in Michigan in interview taped by radio reporter Jan Gorham for later broadcast over WCAR, Detroit.

George Gullen, president of Wayne State University, addresses Auxiliary members and guests at interfaith prayer breakfast held in Pontchartrain Oct. 9.

Mrs. Fleming A. Barbour (left), of Flint, passes along MSMS Auxiliary's president's pin to Mrs. William J. Jones, of Allen Park, during installation ceremonies. Auxiliary's annual convention was held in Pontchartrain Hotel coinciding with MSMS House of Delegates and Scientific Session.

Dates to remember

The 1974 Annual Session of the MSMS House of Delegates will be held next May 5, 6 and 7 at Boyne Mountain. The speaker of the House of Delegates is empowered to call a fall meeting on a basis of business requiring the attention of delegates. By action of the house in October in Detroit, officers chosen for 1973-74 will serve until the Annual Session to be held in the Spring of 1975, completing the change of the society's major business meeting from fall to spring.

For the present, the annual Scientific Session will continue in the fall. The next Scientific Session will be held in October, 1974, in Detroit.

Gov. Milliken pauses to greet Mrs. Charles H. Willison, of Midland, wife of MSMS delegate from Midland County, after addressing House.

Gala installation dinner Oct. 8 was the social highlight of the 1973 Annual Session.

Five physicians receive awards for distinction

The Michigan State Medical Society's highest award, its Certificate of Commendation, was presented to five physicians during the 1973 Annual Session. The award has been given annually since 1961 to physicians "who distinguish themselves in the medical profession."

Honored in 1973 were:

William G. Birch, MD, Kalamazoo obstetrician and gynecologist, for his "pioneering efforts to train Type A Physician's Assistants at Western Michigan University."

James F. Dooley, MD, Flint family physician, for his "tireless efforts to establish the Family Practice Clubs now operating at the three Michigan medical schools."

Jacques S. Gottlieb, MD, of Detroit, a psychiatrist and director of Lafayette Clinic, for "outstanding leadership in the development of the Lafayette Clinic and as chairman of the Wayne State University School of Medicine Department of Psychiatry."

Arthur W. Strom, MD, a specialist in internal medicine in Hillsdale, "for his leadership in the establishment of the coronary care unit and as longtime chief of medicine at the Hillsdale Community Health Center."

Robert K. Whiteley, MD, Detroit obstetrician and gynecologist, for "distinguished civic service on the Grosse Pointe Board of Education" and contributions to medical organizations.

All five were present to receive their awards during the 1973 Annual Session. George D. Stilwill, MD, of Lansing, served as chairman of the selection committee.

John J. Coury, MD (right), MSMS president for 1972-73, presents a Certificate of Commendation to William G. Birch, MD, of Kalamazoo . . .

. . . to James F. Dooley, MD, (right), of Flint, . . .

. . . to Jacques S. Gottlieb, MD, (left), of Detroit

. . . to Arthur W. Strom, MD, (left), of Hillsdale, and to

. . . Robert K. Whiteley, MD, (left), of Detroit.

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Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

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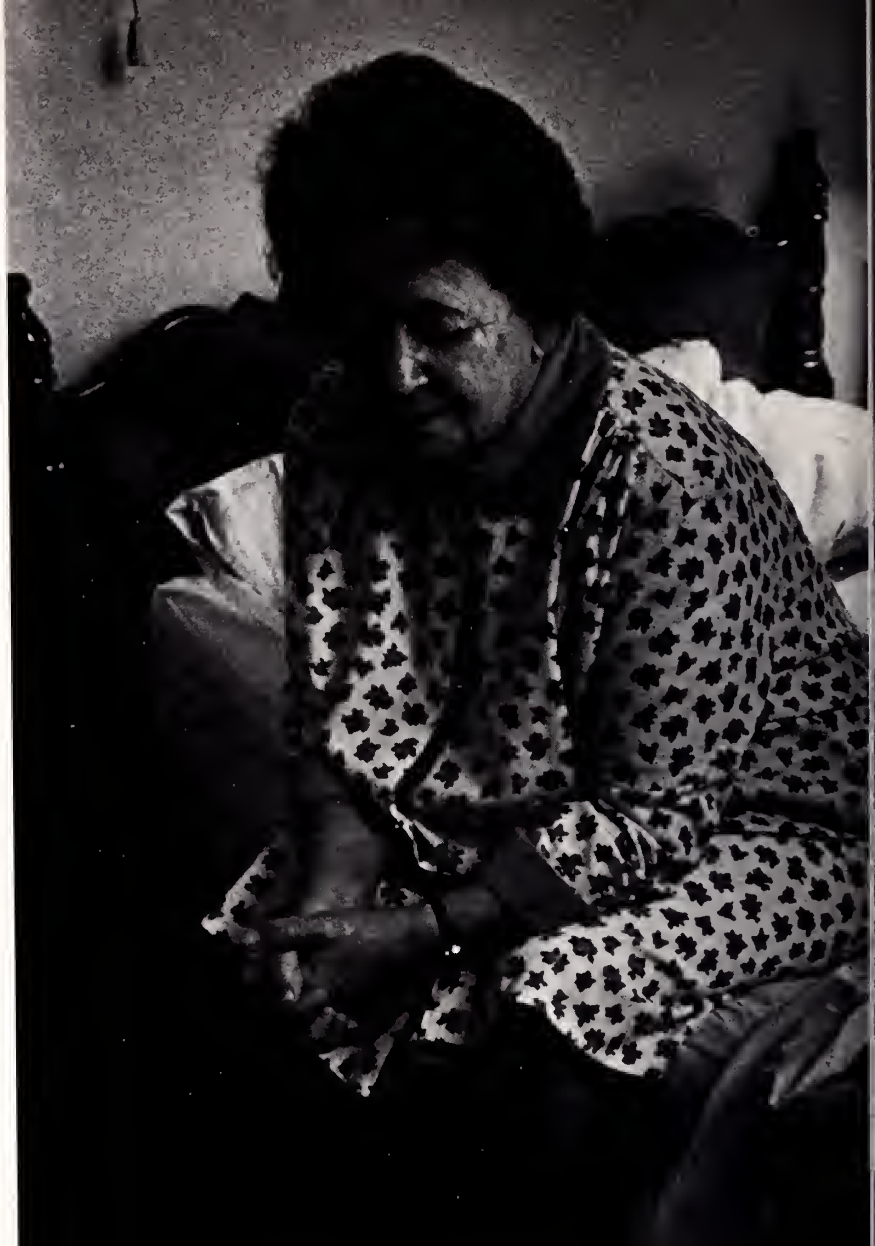
Precautions—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitryptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

Adverse Reactions—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 305432



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quality medical care, I urge every component society to accept the MSMS offer to provide speakers and programs for component meetings.

These, then, are some of the problems which face us in the coming year. How can we best approach their solution? No profession has as many potential leaders and problem-solvers as we have in medicine. Medical students are carefully screened before they are accepted, and their success depends upon discipline, initiative, and hard work. Facing the basic issues of life as we do, doctors are aware that the problems listed, and many more, cry out for viable solutions. The question continues to be: How can we motivate more doctors to accept positions of leadership? How can MSMS train future leaders? How can we involve more of the younger doctors?

MSMS must find ways of asking our members what they think. What are their opinions? It is not enough to direct information at the members; we must find new ways to listen. Every member of the House of Delegates and the MSMS Council must work every day at improving the two-way communications between MSMS and the individual physician, whether or not he happens to be a member.

In addition, those of us in private practice realize that MSMS must include the views of the doctors in the medical schools, those in public health, those in research labs. We must all work together to resolve the concerns of every licensed doctor of medicine in Michigan, and every student in the medical schools.

MSMS must involve more students and house staff members in positions of decision making. We must be concerned with the minorities. I am personally pleased with the progress MSMS has made in working cooperatively with the black physicians, with those in the medical schools and with those in governmental positions.

There is great need for unity. But unity must not come in the form of new organization that resembles the labor unions, for that would not represent all our points of view. And the idea of responding to ultimatums from labor bosses is very foreign to our training and principles. No, unity must not equal conformity.

One of my major goals this coming year will be to work for greater unity within our profession. Once this is accomplished, then we may begin to work more effectively with non-medical groups. During the year I hope to address a number of other allied professional groups, presenting our views and seeking ways of working constructively together for the good of all.

If we do not face the health problems in a positive, creative, aggressive manner, then others will do it for us. Our founding fathers believed that government exists for the purpose of giving order to society. The inability of private enterprise to squarely face today's problems has given birth to the idea that government exists to order society. For 108 years, we have had freedom in the practice of medicine, but today we stand in daily danger of losing those cherished freedoms.

Port Huron medical assistant named to national office

Betty Lou Willey, a certified medical assistant (CMA) from Port Huron was unanimously elected president-elect of the American Association of Medical Assistants Oct. 24 at the 17th annual convention in Washington, D.C.

Mrs. Willey, office manager and medical assistant to William T. Davison, MD, and Juan E. Olivera, MD, has been active in local, state and national chapters of AAMA.

The new president-elect has served as Speaker of the AAMA House of Delegates for five years and also as vice-speaker and vice-president. She has also held the offices of president, president-elect, treasurer, recording secretary, speaker of the house and parliamentarian of the Michigan State chapter of AAMA.

Mrs. Willey is the founding president and a member of the organizing committee of the St. Clair County Medical Assistants Chapter of AAMA and has served as chairman and a member of various chapter committees.

The Chicago-based AAMA is a national organization of more than 15,500 medical assistants who work under the direct supervision of a licensed physician. One of the major objectives of the association is to increase the education and professionalism of medical assistants.

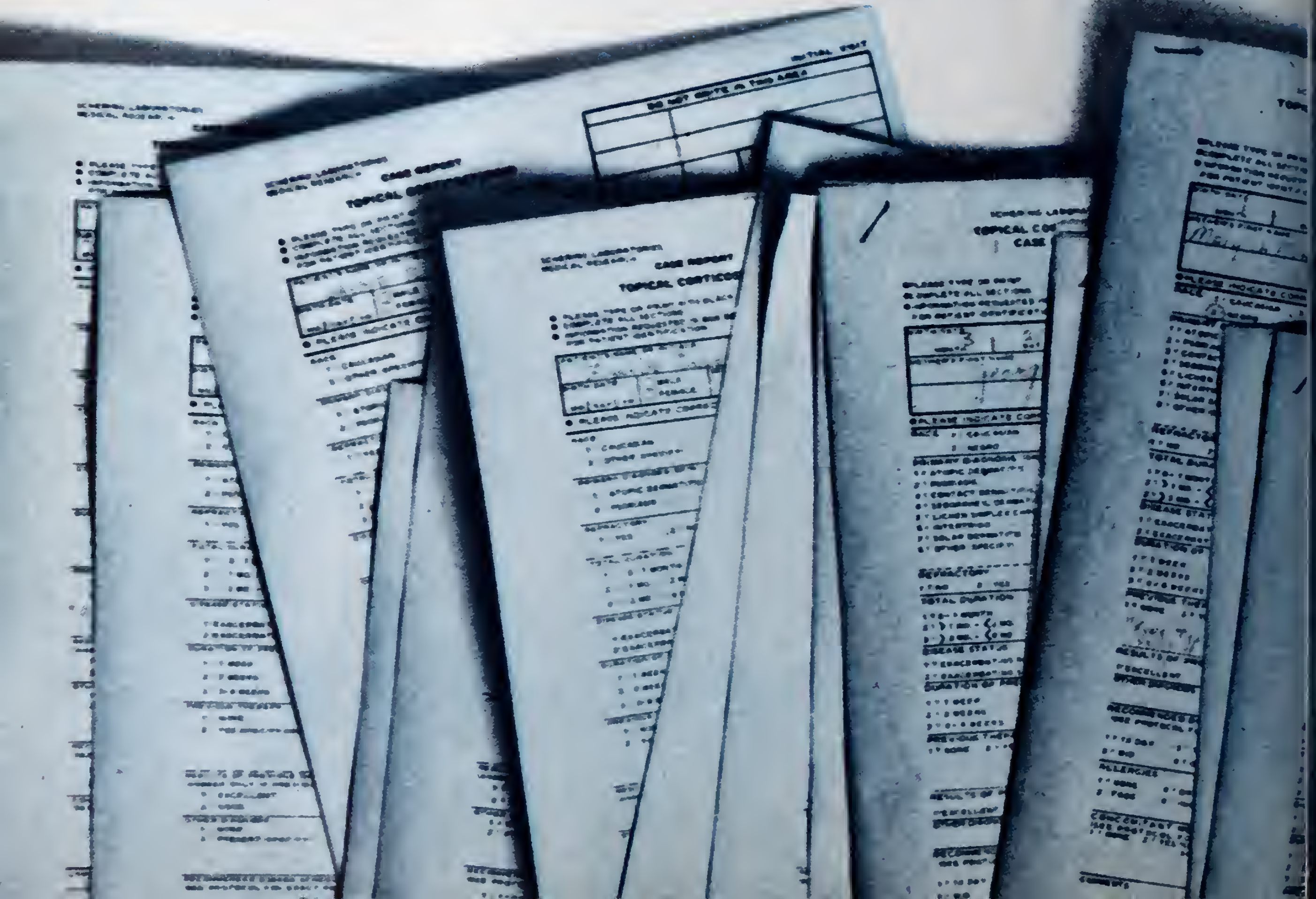
A topical steroid that has clinically succeeded

in study...after study...after study[1-6]

Excellent/good results

85% in psoriasis *(150 of 177 patients)*[1]

92% in atopic ecz *(231 of 251 patients)*[1]



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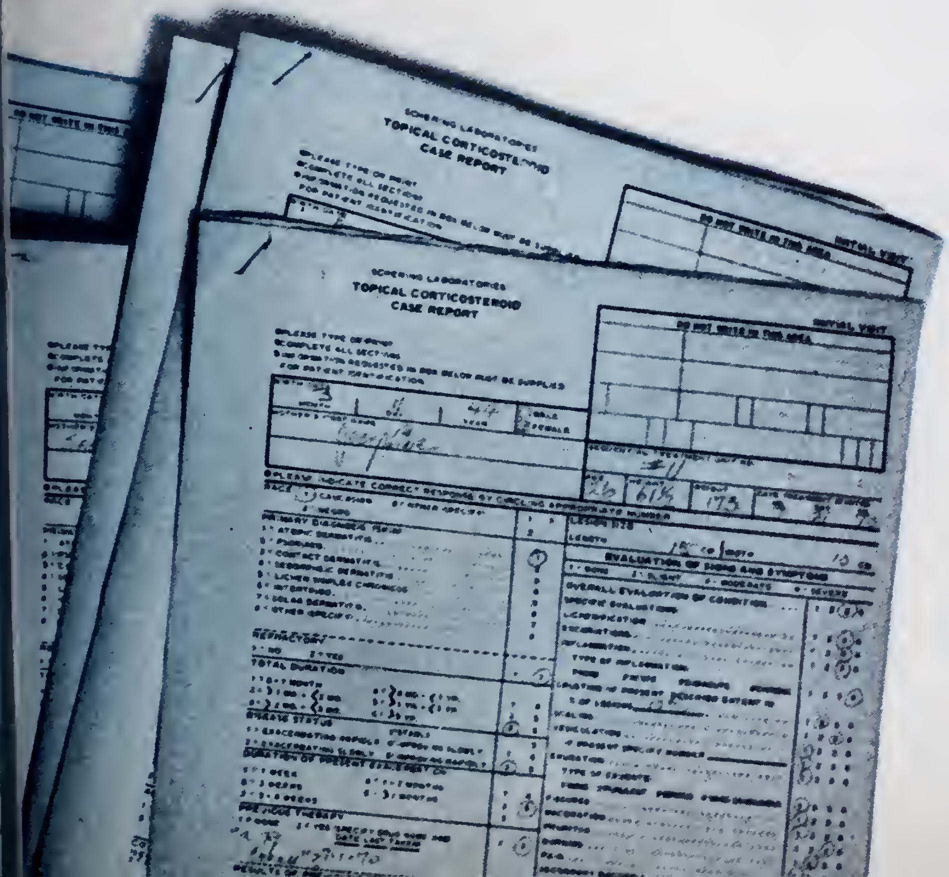
Available in 5, 15, and 45 Gm. tubes.

96% in contact dermatitis

(81 of 84 patients)[1]



SCHERING LABORATORIES
TOPICAL CORTICOSTEROID
CASE REPORT

CLINICAL CONSIDERATIONS:

Description VALISONE products contain betamethasone valerate (9-fluoro-11$_\beta$,17,21-trihydroxy-16$_\beta$-methylpregna-1,4-diene-3,20-dione 17-valerate). Each gram of VALISONE Cream 0.1% contains 1.2 mg. betamethasone valerate (equivalent to 1.0 mg. betamethasone) in a soft, white, hydrophilic cream of water, mineral oil, petrolatum, polyethylene glycol 1000 monocetyl ether, cetostearyl alcohol, monobasic sodium phosphate, and phosphoric acid; 4-chloro-m-cresol is present as a preservative. Each gram of VALISONE Ointment 0.1% contains 1.2 mg. betamethasone valerate (equivalent to 1.0 mg. betamethasone) in an ointment base of liquid and white petrolatum, and hydrogenated lanolin. VALISONE Cream and Ointment contain no parabens.

Indications VALISONE Cream and Ointment are indicated for the relief of the inflammatory manifestations of corticosteroid-responsive dermatoses.

Contraindications VALISONE Cream and Ointment are contraindicated in vaccinia and varicella. Topical steroids are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.

Precautions If irritation develops with the use of VALISONE Cream or Ointment, treatment should be discontinued and appropriate therapy instituted. In the presence of an infection, the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled. If extensive areas are treated or if the occlusive technique is used, the possibility exists of increased systemic absorption of the corticosteroid and suitable precautions should be taken. Although topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use in pregnant females has not been absolutely established. Therefore, they should not be used extensively in pregnant patients, in large amounts, or for prolonged periods of time. VALISONE Cream and Ointment are not for ophthalmic use.

Adverse Reactions The following local adverse reactions have been reported with topical corticosteroids: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneform eruptions, and hypopigmentation. The following may occur more frequently with occlusive dressings than without such therapy: maceration of the skin, secondary infection, skin atrophy, striae, and miliaria.

Dosage and Administration Apply a thin film of VALISONE Cream or Ointment to the affected skin areas one to three times a day. Clinical studies of VALISONE have indicated that dosage only once or twice a day is often feasible and effective. AUGUST 1972

For more complete details, consult Schering literature available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.

References: *(1) Files of Headquarters Medical Research Division, Schering Corporation. (2) Carter, V. H., and Noojin, R. O.: Curr. Therap. Res. 9:253, 1967. (3) Falk, M. S.: Cutis 2:788, 1966. (4) Goldblum, R. W.: Pennsylvania Med. 69:50, 1966. (5) Nierman, M. M.: J. Indiana M. A. 10:1184, 1966. (6) Zimmerman, E. H.: Arch. Dermat. 95:514, 1967.*

SLR-439

MSMS action

Judicial Commission issues statement on jurisdiction

The MSMS Judicial Commission, after consideration of questions as to types of cases it should accept, has issued a new statement of policies on jurisdictional matters.

The new policy statement follows:

1. The Commission will give favorable consideration to original jurisdiction requests sought by MSMS component societies.
2. The Commission will continue to exercise its discretion as to taking cases of original jurisdiction, from whatever source, giving preference to questions and topics of state wide significance.
3. The Commission will necessarily give low priority to original jurisdiction requests which appear to deal with isolated instances or non-recurring topics.
4. The Commission will not take jurisdiction from complainants who are not society members, save for infrequent problems which are novel or of grave import.
5. The Commission will from time to time consider broad ethical questions, whether on original jurisdiction, or appeal, or whether taken up by the Commission on its own initiative.
6. The Commission recognizes that many problems of peer review and professional standards can involve ethical concepts which are of direct interest to the Commission. Because peer review and professional standards are handled by other bodies, the Commission will decline such examinations except under limited circumstances and then only to pass upon ethical questions rather than repeating the professional review.
7. The principles above enunciated will also serve as indicia to the Commission's posture with respect to cases sought to be appealed, subject to the necessity for orderly handling of those appellate matters which it is inherently obligated to hear.

The statement was issued by Robert J. Mason, MD, of Birmingham, chairman of the Judicial Commission. Doctor Mason has announced his intention to leave the commission on Dec. 1 and his plans to retire from medical practice in Michigan.

Doctor Knights asks involvement by foreign medical graduates

Thoughts about increasing the participation of foreign-trained physicians in Michigan component medical societies were expressed by Oakland County President-Elect Edwin M. Knights, Jr., MD, in the October issue of the Oakland Bulletin.

In part, Doctor Knights wrote:

"It is apparent that while foreign medical graduates are making a significant cultural contribution to Oakland County, the medical society has not yet succeeded in getting them involved in medical matters to the degree that many have received positions of responsibility in the organization. As a result, we are not representative of their needs or possibly their points of view.

"How can this be alleviated? Perhaps, there should be a required 'indoctrination course' in which new members are required to participate—they could meet the officers, board members and committee chairmen and learn of opportunities to participate and acquire some of their philosophy of medical practice. Genesee County Medical Society used this system successfully for many years.

"Perhaps, some foreign medical graduates have other suggestions.

"Certainly, greater participation in committees should be encouraged; this is where much of the work of the medical society is performed and where the foreign medical graduate can become acquainted and develop the confidence of his fellow physicians. If we do not succeed in getting foreign medical graduates interested in Oakland County Medical Society, we will have lost a most valuable asset to our organization and will have failed in providing them with equal opportunity or representation."

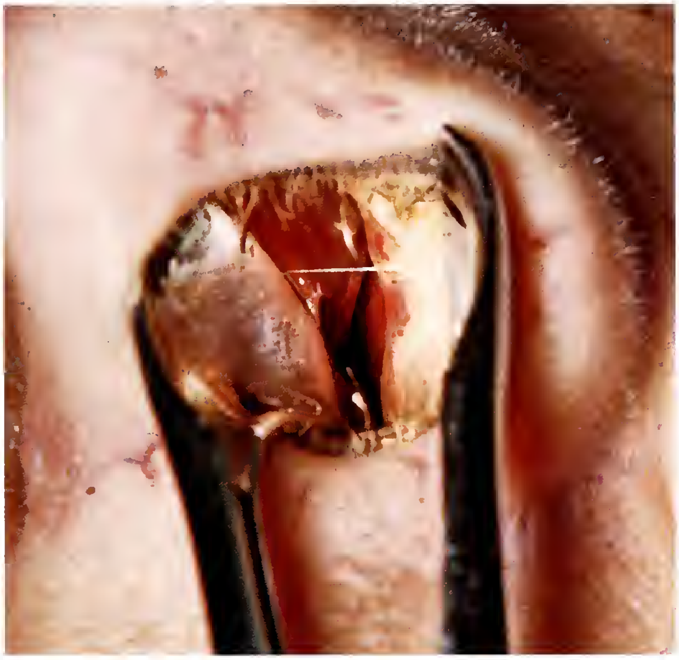
Note: Doctor Knights reported in his article that of 883 OCMS members, 190 had received their medical education outside of the USA.

Maybe the patient's self-diagnosis is right. He could have hay fever. But that bright red nasal mucosa, along with the thick discharge and excoriation around the nares, strongly suggests that the main problem is a cold. Hay fever or another form of allergic rhinitis may or may not be an underlying factor.

If a complete history and examination rule out allergic rhinitis, the long-term outlook will be a lot more favorable than his own "diagnosis" would have indicated.

But right now, whether he's got allergic rhinitis or a cold, he's suffering from the same irritating symptoms of drip, congestion and stuffiness. Try DIMETAPP EXTENTABS®. They're formulated to relieve these symptoms without much chance of causing drowsiness or overstimulation. Your patients will appreciate the 24-hour relief they can get from just one tablet every 12 hours.

Cold or



Allergy?

Whether it's a cold or an allergy, Dimetapp Extentabs® effectively relieve stuffiness, drip and congestion.

INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.
CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.
WARNINGS: *Use in children.* In infants [illegible]

[illegible]

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

[illegible]

A·H·ROBINS

when pain goes on... and on... and on–

For the patient with a terminal illness, PAIN past, present, and future can dominate his thoughts until it becomes almost an obsession. The more he is aware of the pain he is now experiencing, the more difficult it is to erase his memory of yesterday's pain, and to allay his fearful anticipation of tomorrow's pain.

Surely the last thing this patient needs is an analgesic containing caffeine to stimulate the senses and heighten pain awareness. A far more logical choice is Phenaphen with Codeine. The sensible formula provides ¼ grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can help control the pain more effectively. Don't you agree, Doctor, that psychic distress is an important factor in most of your terminal and long-term convalescent patients?

the analgesic formula that calms instead of caffeinates

Phenaphen® with Codeine

Phenaphen with Codeine No. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg; Phenacetin (3 gr.), 194.0 mg; Codeine phosphate, ¼ gr (No. 2), ½ gr (No. 3) or 1 gr (No. 4) (warning: may be habit forming)

Indications: Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

(III) Phenaphen with Codeine is now classified in Schedule III, Controlled Substances Act of 1970. Available on written or oral prescription and may be refilled 5 times within 6 months, unless restricted by state law.

A. H. Robins Company, Richmond, Va. A·H·ROBINS

Michigan mediscene

Nov. 13-14—MSMS and AMA Seminar on "Establishing Yourself in Medical Practice," MSMS headquarters, contact: Richard Campau, MSMS, 120 W. Saginaw St., East Lansing, Mich. 48823

Nov. 28—Physician postgraduate course, "Human Hypersensitivity Disorders: Clinical Aspects and Pathogenetic Mechanisms," sponsored by American College of Physicians, at the U-M Medical Center, Ann Arbor, contact: ACP, 4200 Pine St., Philadelphia, Pa. 19104

Nov. 28—Annual thyroid workshop sponsored by Thyroid Service of the Wayne State University School of Medicine, at Scott Hall, WSU, Detroit, contact: Howard Dworkin, MD, William Beaumont Hospital, 3601 W. 13 Mile Rd., Royal Oak, Mich. 48072

Nov. 29—Professional Activity Study and Medical Audit Program Institute, sponsored by Commission on Professional and Hospital Activities, at CPHA headquarters, Ann Arbor, AAFP elective hours, contact: CPHA, 1968 Green Rd., Ann Arbor, Mich. 48105

Dec. 1-4—AMA 1973 Clinical Convention on "New Dimensions in Continuing Education," Anaheim, Cal., contact: Clinical Convention Coordinator, AMA, 535 N. Dearborn St., Chicago, Ill. 60610.

Dec. 5-6—Postgraduate course on "Advances in Ophthalmology" sponsored by the Cleveland Clinic Educational Foundation, at the clinic, Cleveland, contact: Linda L. Bitonti, Education Secretary, Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland, Ohio 44106.

Dec. 7-8—Twenty-first annual symposium on trauma sponsored by the Michigan committee on trauma of the American College of Surgeons and the Wayne State University School of Medicine, at Wayne County Medical Society headquarters, Detroit, contact: Joseph L. Posch, MD, Suite 1408, Kales Building, 76 W. Adams, Detroit, Mich. 48226.

Dec. 8—Seminar on "Diseases of the Endometrium and Uterus" sponsored by the Michigan Society of Pathologists, at Rackham Auditorium, U-M, Ann Arbor, contact: Jacob E. Briski, MD, St. John Hospital, 22101 Moross Rd., Detroit, Mich. 48236.

Jan. 15, 1974—Midwinter board meeting, MSMS Auxiliary, at MSMS headquarters, East Lansing, contact: Mrs. William J. Jones, president, 15839 Crescent Dr., Allen Park, Mich. 48101.

Jan. 16, 1974—Lecture on acupuncture by William M. Lukash, MD, White House physician, sponsored by William Beaumont Hospital Research Institute, at the hospital in Royal Oak, contact: Research Institute, Beaumont Hospital, 3601 W. 13 Mi. Rd., Royal Oak, Mich. 48072.

March 7, 1974—Professional Activity Study and Medical Audit Program Institute, sponsored by Commission on Professional and Hospital Activities, at CPHA headquarters, Ann Arbor, AAFP elective hours, contact: CPHA, 1968 Green Rd., Ann Arbor, Mich. 48105.

March 15-16, 1974—Second Annual National Conference on Human Nutritional Aspects of Kidney Disease and Renal Failure sponsored by the Kidney Foundation of Michigan, Michigan Renal Dietitians and the Michigan State University School of Nutrition, at Kellogg Center, MSU, East Lansing, contact: Ms. Jean Bruge, Michigan Nephrology Center, Borgess Hospital, 1521 Gull Rd., Kalamazoo, Mich. 49001.

March 18-21, 1974—Physician postgraduate course "Rheumatic Disease: Pathogenesis, Diagnosis and Treatment," sponsored by American College of Physicians, at U-M Medical Center, Ann Arbor, contact: ACP, 4200 Pine St., Philadelphia, 19104.

March 27-28, 1974—Annual Michigan Conference on Maternal and Perinatal Health, the Pantlind Hotel, Grand Rapids, contact: Lloyd Kammeraad, MD, 1810 Wealthy St., SE, Grand Rapids, Mich. 49506, or Helen Schulte, MSMS Headquarters.

April 24, 1974—Annual Legislative Day, MSMS Auxiliary, at Olds Plaza Hotel, Lansing, contact: Mrs. Robert J. Westerhoff, 2458 Maplewood, SE, Grand Rapids, Mich. 49506.

April 24-25, 1974—Annual Spring Conference, MSMS Auxiliary, at Hospitality Inn, Lansing, contact: Mrs. William J. Jones, president, 15839 Crescent Drive, Allen Park, Mich. 48101.

April 25-26, 1974—27th National Conference on Rural Health sponsored by the AMA Council on Rural Health at the Detroit Hilton Hotel, contact: Bond L. Bible, PhD, Department of Rural Health, AMA, 535 N. Dearborn St., Chicago, Ill. 60610.

May 1-3, 1974—Michigan Public Health Association Annual Meeting, Statler-Hilton Hotel, Detroit, contact: MPHA, 403 Seymour Ave., Lansing, Mich. 48914.

Michigan Mediscene each month lists upcoming meetings in Michigan or, if out of state, of special interest to Michigan physicians. Please submit meeting notices for listing at least two months prior to meeting dates to **Michigan Medicine**, 120 W. Saginaw St., East Lansing, Mich. 48823.

Everybody experiences psychic tension.

Most people can handle this tension.

Some people develop excessive psychic tension and need your counseling.

and a few may need counseling
and the psychotropic action of Valium® (diazepam).

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nd, if so, what his response has
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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.

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(diazepam)

To help you manage excessive psychic tension

Socio-economic

Towns with top medical facilities attract, hold most new doctors

By Alan Ira Kubrin, MS
Ann Arbor

The quanitity and quality of medical facilities in a community seem to be the principal factors in attracting and holding physicians, according to a statistical study prepared recently for the MSMS Bureau of Economic Information.

This calls into question, at least for the State of Michigan, much of the conventional wisdom and previous research that assign primary importance for doctor location to population size.

Excellent medical practice requires excellent facilities. Physicians will be most attracted to those areas that can provide these facilities. This is particularly true of specialists for whom facilities are essential, but it is also true for the general practitioner who knows that there are specialists in the area to whom he can refer patients.

Many factors are significant in determining the number of physicians in a community, our research shows. Socio-economic and demographic characteristics of the community, as well as institutional factors, were considered to determine where doctors locate.

Michigan counties were divided into three population sizes: 20,000 persons or less, 20,000 to 100,000 persons and more than 100,000 persons. Wayne county was excluded.

Rather than population, availability of medical facilities seems to be the principal predictor of physician distribution. It is indeed the only significant predictor for the smaller group of counties and is by far the most important predictor for the total group.

The study found that availability of medical facilities appears to be the only significant determinant of physician numbers in the small county. Yet, "unmeasurables," such as the ties of a doctor to his home county, are most important in the small, rural counties.

The most important factor in attracting and holding physicians in the middle-sized county seems to be a high percentage of people who also work there. In larger counties, community resources seem to attract physicians.

Knowledge about the need and demand for health care can assist both private and public decision making. Manpower estimates can aid the recently-licensed physician in his decision on where to locate his practice. It can assist governmental authorities in their decision of where to encourage hospital construction. It can thus help rationalize the use of the nation's resources, both human and capital.

Our analysis recognizes that attributes of certain communities will affect their demand and need for medical services. And these attributes may be "glossed over" in any gross national analysis. Among them are population densities, the percentage of non-white population, the percentage under 18 and over 65 year of age, median years of schooling of males 25 and older, median incomes, median rents, percentage of residents working in their home communities and number of hospital beds.

The size of population generally determines the number of doctors. Not only does population size serve to set the outer limits on the number of doctors a community can support, but it also establishes feasibility limits for the size of the corps of medical specialists. A certain threshold population level is necessary for the support of specialized medical practice.

We found in the study, overall, that the more dense the population, the higher the median income, the higher the median home value, the higher the median rental fee, the better the facilities, the more physicians there are in that county.

The study showed that the more poor present, the fewer MDs. There was no significant correlation between non-white population and low numbers of MDs. Although we had predicted more MDs where there were more persons under 18, the reverse was shown in the study.

The fact that a large percentage of the population worked in its own community seemed to have an effect on physician numbers only in the middle-sized counties, and it seemed to have no effect in the small or large counties.

The author is a researcher in Ann Arbor. His findings are his own and do not reflect MSMS viewpoints or positions. They were gathered to supplement MSMS information. Further details may be obtained from John H. Anthony, chief, MSMS Bureau of Economic Information.

Must vasodilators and therapy for other diseases come into conflict?

not if the vasodilator is

VASODILAN®

(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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MeadJohnson LABORATORIES

Small doses

James E. Baker, MD, of Battle Creek

was paid high civic tribute as he left his position as director of the Battle Creek Veterans Administration Hospital. Doctor Baker has been named to head a VA neuropsychiatric hospital at Brockton, Mass. He had been director of the hospital in Battle Creek for six years.

George M. Brown, MD, of Bay City

has retired from practice after 51 years in Bay City as a family doctor and proctologist. Doctor Brown was graduated from the University of Michigan Medical School in 1920 and in 1922 opened his office in a Bay City home built in the 1880s. He closed the same office at the end of September. Doctor Brown is a past president of his county medical society and has been chief of staff at both General and Mercy Hospitals in Bay City. Doctor Brown served as president of the Bay County chapter of the Michigan Society for Crippled Children and Adults for 25 years. Because of his service to crippled children, a new orthopedic center opened in Bay City in 1971 was named in his honor. He received a 50 year award from MSMS in 1972.

Sol C. Grossman, MD, of Huntington Woods

has been promoted to associate clinical professor in the Department of Psychiatry at the Wayne State University School of Medicine. He also was presented a certificate of appreciation for his continuing outstanding contribution to the psychiatry training program at Sinai Hospital of Detroit.

Dewey R. Heetderks, Jr., MD, of Grand Rapids

is the new president of the medical staff at Butterworth Hospital, Grand Rapids.

Francis L. Purcell, MD, of Ypsilanti

has been named to the campaign cabinet for the 1973 Washtenaw County United Fund Campaign. Doctor Purcell, who is medical director of the Hydra-matic Division of General Motors Corporation, heads the Hospital and Social Agencies Division of the campaign.

Clara Raven, MD, of Detroit,

has been appointed by Governor Milliken to the State Public Health Advisory Council to succeed Oscar Stryker, MD, of Mt. Clemens. Her term will expire May 30, 1975.

(Continued on page 806)

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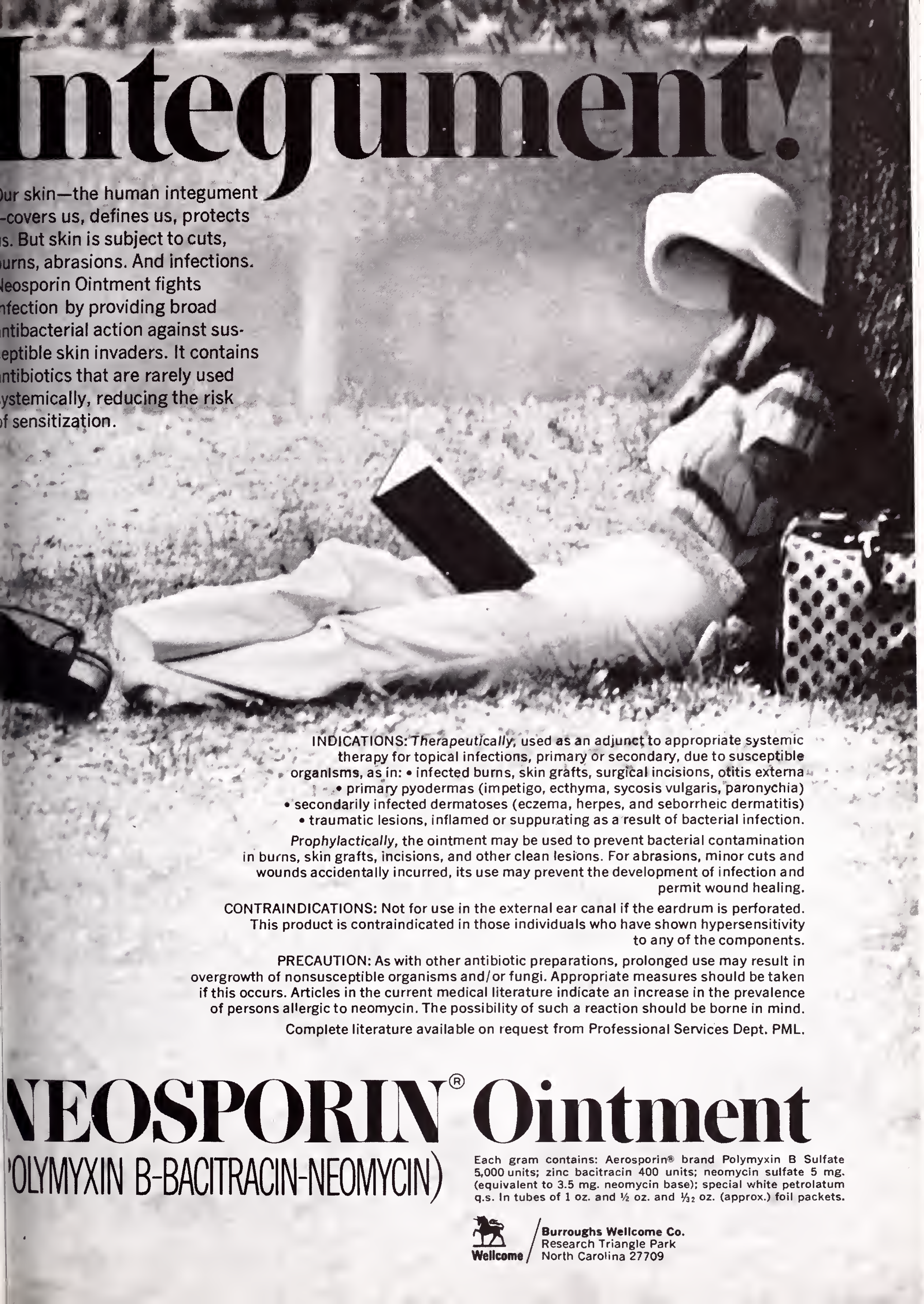

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Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

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Bernard M. Schuman, MD, of Detroit

has been elected president of the Detroit Gastroenterological Society. He also serves as secretary of the American Society for GI Endoscopy.

Three Lansing Physicians

gave scientific presentations at the 1973 annual meeting of the Michigan Society of Radiologic Technologists held in September in the Olds Plaza Hotel in Lansing. Thomas C. Payne, MD, and Arthur M. Budden, MD, gave a presentation on "Chest Pathology," and Robert Brantley, MD, conducted a program on "Pathology of Abdominal Angiography."

Two Michigan Doctors

have been appointed to a 100-member national committee designed to move established findings of cancer research more quickly into the general practice of medicine and public health. They are Michael J. Brennan, MD, of Grosse Pointe, president of the Michigan Cancer Foundation, and Robert L. Tupper, MD, director of medical education at Blodgett Hospital, Grand Rapids. The effort was authorized by the National Cancer Act of 1971.

Three Detroit Surgeons

were honored Oct. 16 in Chicago for their work on a new film, "Below Knee and Transmetatarsal Amputations for Diabetics," which was premiered at the 59th annual Clinical Congress of the American College of Surgeons. The Detroit physicians, Melvin A. Block, MD; Hubert M. Allen, MD, and Thomas A. Fox, MD, from Henry Ford Hospital, received a commemorative plaque for the film, which demonstrates their work in specialized surgery.

Arthur L. Tuuri, MD, of Flint

was paid high civic tribute Sept. 19 for his 25 years of service as director of the Mott Children's Health Center, which was founded in Flint in 1939. Doctor Tuuri had just completed residency training in pediatrics at University Hospital in Ann Arbor when he became director of the center in 1948. Commenting editorially on the honor paid Doctor Tuuri, the Flint Journal said "The entire community is a better place for his being here." A seminar on diagnosis and treatment of children with learning disabilities was held as part of the day's activities.

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HELPS PREPARE WOUND FOR:

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CLEANSE WOUND
Thoroughly cleanse and irrigate wound area with sodium chloride or water solutions. Wound MUST be cleansed of antiseptics or heavy-metal antibacterials.

THOROUGHLY MOISTEN
Thoroughly moisten wound area either through tubbing, showering, or wet soaks (e.g., sodium chloride or water solutions).

APPLY ENZYME
Apply a layer of TRAVASE Ointment. Assure intimate contact with necrotic tissue and complete wound coverage.

APPLY MOIST DRESSING
Apply loose moist dressings (most important with dry leathery eschar).

CHANGE DRESSINGS
When changing dressing, gently wipe away the dissolved material. Repeat the procedure, including application of TRAVASE Ointment, 3 to 4 times per day for best results.

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Ulcers secondary to peripheral vascular disease.

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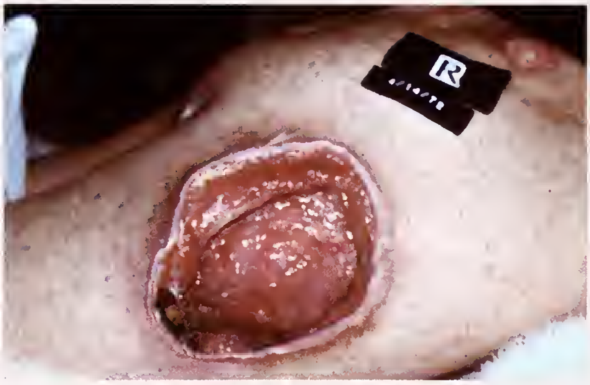
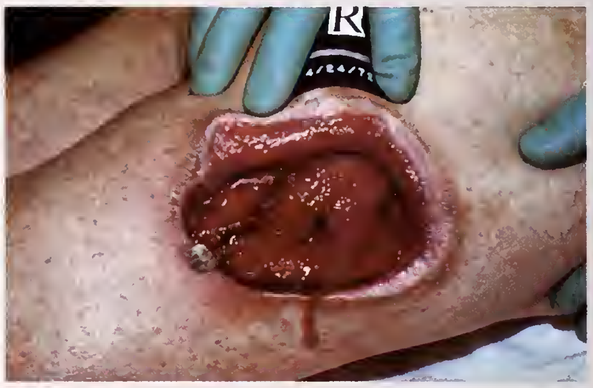
ulcers

TERRY V. CARLE, M.D., CLINICAL INSTRUCTOR, DEPT. OF PHYS. MED. & REHAB.,
CRAIG REHABILITATION HOSPITAL, UNIVERSITY OF COLORADO



Before treatment, necrotic matter coated the inner surfaces of this decubitus ulcer.



After nine days of TRAVASE therapy, debridement is nearly complete and granulation evident.

burns

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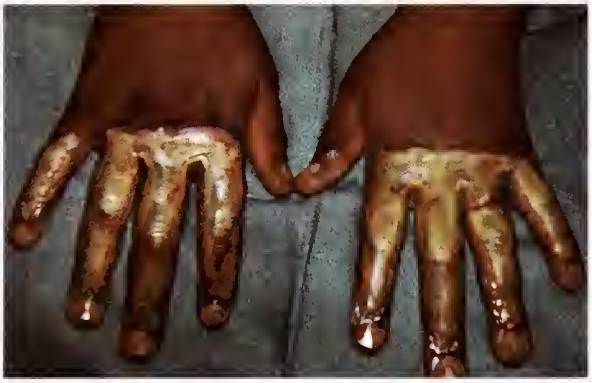
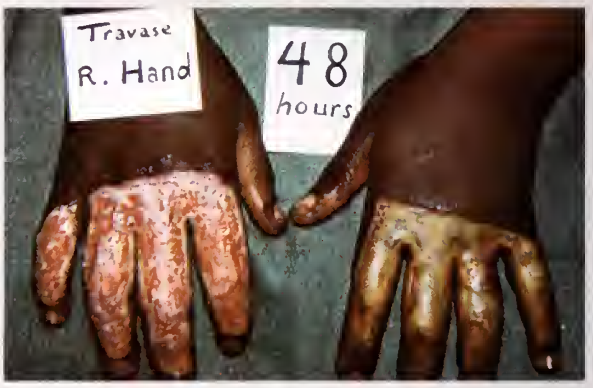


Before treatment . . .



48 hours following treatment with TRAVASE Ointment on right hand; left hand is control.

Travase® Ointment

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Indications: For wound debridement, TRAVASE Ointment is indicated as an adjunct to established methods of wound care for biochemical debridement of the following lesions:

Second and third degree burns,
Decubitus ulcers,
Incisional, traumatic, and pyogenic wounds,
Ulcers secondary to peripheral vascular disease.

Contraindications: Application of TRAVASE Ointment is contraindicated in the following conditions:

Wounds communicating with major body cavities,
Wounds containing exposed major nerves or nervous tissue,
Fungating neoplastic ulcers,
Wounds in women of child-bearing potential—because of lack of laboratory evidence of effects of TRAVASE upon the developing fetus.

Warning: Do not permit TRAVASE Ointment to come into contact with the eyes. If contact is made, immediately rinse with copious amounts of water, preferably sterile.

Precautions: A moist environment is essential to optimal activity of the enzyme. Enzyme activity may also be impaired by certain agents (see package insert). Although there have been no reports of systemic allergic reaction in humans, studies have shown that there may be an antibody response in humans to absorbed enzyme material.

Adverse Reactions: Consist of mild, transient pain, paresthesias, bleeding and transient dermatitis. Pain usually can be controlled by administration of mild analgesics. Side effects severe enough to warrant discontinuation of therapy occasionally have occurred.

If bleeding or dermatitis occurs as a result of the application of TRAVASE Ointment, therapy should be discontinued. No systemic toxicity has been observed as a result of the topical application of TRAVASE Ointment.

DOSAGE AND ADMINISTRATION: STRICT ADHERENCE TO THE FOLLOWING IS REQUIRED FOR EFFECTIVE RESULTS OF TREATMENT:

1. Thoroughly cleanse and irrigate wound area with sodium chloride or water solutions. Wound MUST be cleansed of antiseptics or heavy-metal antibacterials which may denature enzyme or alter substrate characteristics (e.g., hexachlorophene, silver nitrate, benzalkonium chloride, nitrofurazone, etc.).
2. Thoroughly moisten wound area either through tubbing, showering, or wet soaks (e.g. sodium chloride or water solutions).
3. Apply TRAVASE Ointment in a thin layer assuring intimate contact with necrotic tissue and complete wound coverage extending ¼ to ½ inch beyond the area to be debrided.
4. Apply loose wet dressings.
5. Repeat entire procedure 3 to 4 times per day for best results.

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What will new Certificate of Need legislation mean to Michigan doctors?

By Judith Marr
Owosso

Certificate of need legislation now in effect in Michigan determines the conditions under which the state's hospitals may expand or construct new facilities.

Michigan physicians have many questions about how its application will affect them. Behind all the questions is the nagging thought that the certificate of need concept may someday also govern physicians' plans to expand and build offices and clinics.

Federal law presently gives states the authority to withhold capital expenditure reimbursement for Medicare, Medicaid and Maternal and Child and Youth Programs where capital expenditures for health care facilities in excess of $100,000 have not been approved by state agencies designated by the governor.

Michigan's Law

Present Michigan law covers only hospitals, licensed nursing homes, county medical care facilities and licensed homes for the aged, although in some states certificate of need legislation applies to health care corporations. According to an American Medical Association survey, offices of individual practitioners are excluded in all of the enacted state laws either by omission or by specific exclusion.

At the present time physicians can feel the impact of certificate of need legislation mainly in its effect on the health care facilities where they practice. But Hermann A. Ziel, Jr., MD, chief of the Bureau of Health Facilities for the Michigan Department of Public Health, forecast that state control would be expanded in future legislation.

He predicted that in some future day physicians might be required to apply for certificates of need for construction or remodeling of clinics and offices. Violation of the present law is a misdemeanor.

Under present law, covered facilities cannot be built, converted, added to or modified without certificates of need.

'Consistency' Required

The application for the certificate of need has to be made to the director of the MDPH, and it is issued according to rules drawn up by the state Comprehensive Health Planning Advisory Council. It has to be consistent with the state plan for hospital and medical facility construction.

The MDPH director is to evaluate the application by considering (1) the patterns and level of use, availability and adequacy of existing facilities, institutions and services, (2) the availability and adequacy of services which may serve as alternatives for inpatient or resident care, (3) the possible economies and improvements in services which might be derived from consolidation or affiliation and (4) the availability of manpower.

In considering the application, the MDPH director can obtain documentary evidence of the need, comments from local or area planning agencies and counsel and advice from state health facilities councils.

Michigan is one of more than 20 states which have passed certificate of need legislation. And, as a report by the Council on Medical Service noted at the 1973 AMA Annual Convention, the states' laws vary considerably as to the types of facilities they cover.

"The laws (of the various states) mandate comprehensive health care planning as a means of containing health care costs," according to the AMA report.

"The regulatory concept embodied in the statutes is patterned generally on the regulation of public utilities," with the purpose to promote comprehensive health planning, assist in provision of high quality health care at the lowest possible cost, avoid unnecessary duplication and provide orderly

---

Mrs. Marr formerly served as managing editor of *Michigan Medicine.*

methods for resolving questions concerning the necessity for construction or modification of health care facilities.

Here in Michigan, Doctor Ziel's office already is receiving and processing letters of intent and application from hospitals, which all must now make such application when planning to add on, modernize, construct or convert.

Of great importance in the implementation of the new legislation are the Rules and Regulations Governing the Issuance of Certificate of Need, filed Aug. 15 with the Michigan Secretary of State.

The rules were drawn up by the MDPH with the help of a special committee including representatives of the Michigan Hospital Association, local, areawide and state comprehensive health planning agencies, the state CHP Advisory Council and State Health Facilities Commission.

The rules cover applications for certificates, processing, evaluation, issuance, duration and denial of certificates, appeal and enforcement procedures and roles of various agencies in the certificate of need process.

In Michigan, the MDPH acts as the designated planning agency for implementation of the certificate of need legislation, with appeals to be made to the newly named State Health Facilities Commission. The 11-member commission includes two MDs, Robert D. Coye, MD, dean, Wayne State University School of Medicine, and Edward J. Klopp, MD, Battle Creek practicing physician.

Reaction to the new certificate of need legislation and process in Michigan varies.

The Michigan Hospital Association and Greater Detroit Area Hospital Council supported the legislation and are generally pleased that it's now established procedure.

"We look forward to a constructive relationship with the MDPH in this new tool to make planning effective," said J. Lawrence Buell, Jr., president, at the annual meeting May 16 of the GDAHC.

The Michigan Hospital Association has had no real reaction yet from hospitals around the state because of the newness of the spelled-out regulations, said Edwin Marsh, director of its Hospital Information Center. Marsh served on the special committee advising the MDPH on the formation of the regulations. He reported MHA believes the legislation and regulations to be generally fair.

"We are supportive and have been throughout the legislative process," said Marsh. "We are committed now to making it work." He predicted there will be only spot expansion of hospitals in areas with rapidly growing populations and also that there will be a great number of remodelings and replacements for hospitals built in more lenient times. He said it is wise that there now will be an established process for review of health facility change.

The AMA, in its special report, called for sound criteria nationally as a basis for review of need and added it is necessary that there be adequate and reasonable appeals mechanisms:

"The medical profession generally objects to the concept of government's intervening in a community and private enterprise to determine the need for given health care and medical care facilities and services.

"It might be best stated that certificate of need is a two-edged sword," continued the report. "As much as certificate of need is intended to cut costs, avoid duplication, increase access, etc., it can also stifle competition, be time-consuming and expensive. Competition should be encouraged and new types of incentives should be created for the health and medical care providers."

Certificate of need should be more responsive to the public than to political expediency, the report counseled, and caution should be taken so no special interests have control.

Local Control Sought

Following the presentation of the council's report, the AMA House called for continued support for voluntary planning that preserves decision making at the local level, state laws to rest final authority in a board including practicing physicians and forwarding of recommendations to HEW to be included in regulations.

Doctor Klopp, Michigan physicians' own representative on the legal bodies implementing the new state legislation, described himself as "very ambivalent" in the face of the new process.

"I feel we really need the new legislation because of overlapping services between hospitals which send health care costs up," he said. "But I'm concerned about the controls. I feel this is the beginning of control of all medicine in certain ways. The law can be very confining."

Doctor Klopp said he sees his role on the commission as that of a practicing physician considering the facilities he needs to practice in to make sure the facilities are adequate and that costs are kept down.

Part of Doctor Klopp's ambivalence is because the commission now is operating under a temporary set of rules, with permanent conduct not expected to be okayed by the attorney general for six months or a year.

The commission has met twice but no chairman has been named.

Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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John A. Diddams, MD, 1414 W. Fair Ave., Marquette, 49855
Arnold C. Fellman, MD, 20137 Stratford, Detroit, 48221
Ihsan Ul Haq, MD, 1326 St. Antoine, Detroit, 48226
L. R. Kareti, MD, 1322 E. Michigan Ave., Lansing, 48912
Lyla J. Leipzig, MD, 19309 Greenfield, Detroit, 48235
T. John Lukens, MD, 2710 W. Court St., Flint, 48503
Thomas A. Malec, MD, 245 State St., S. E., Grand Rapids, 49502
Peter K. McLeod, MD, 1828 Genesee Towers, Flint, 48502
James M. McMurtry, MD, 10720 W. Seven Mile Rd. Detroit 48235
David J. Olen, MD, 500 W. Huron St., Pontiac, 48053
Celso C. Samaniego, MD, 721 W. Sixth Ave., Flint, 48503
Sangkyu Shin, MD, 229 S. Gratiot, Mt. Clemens, 48043
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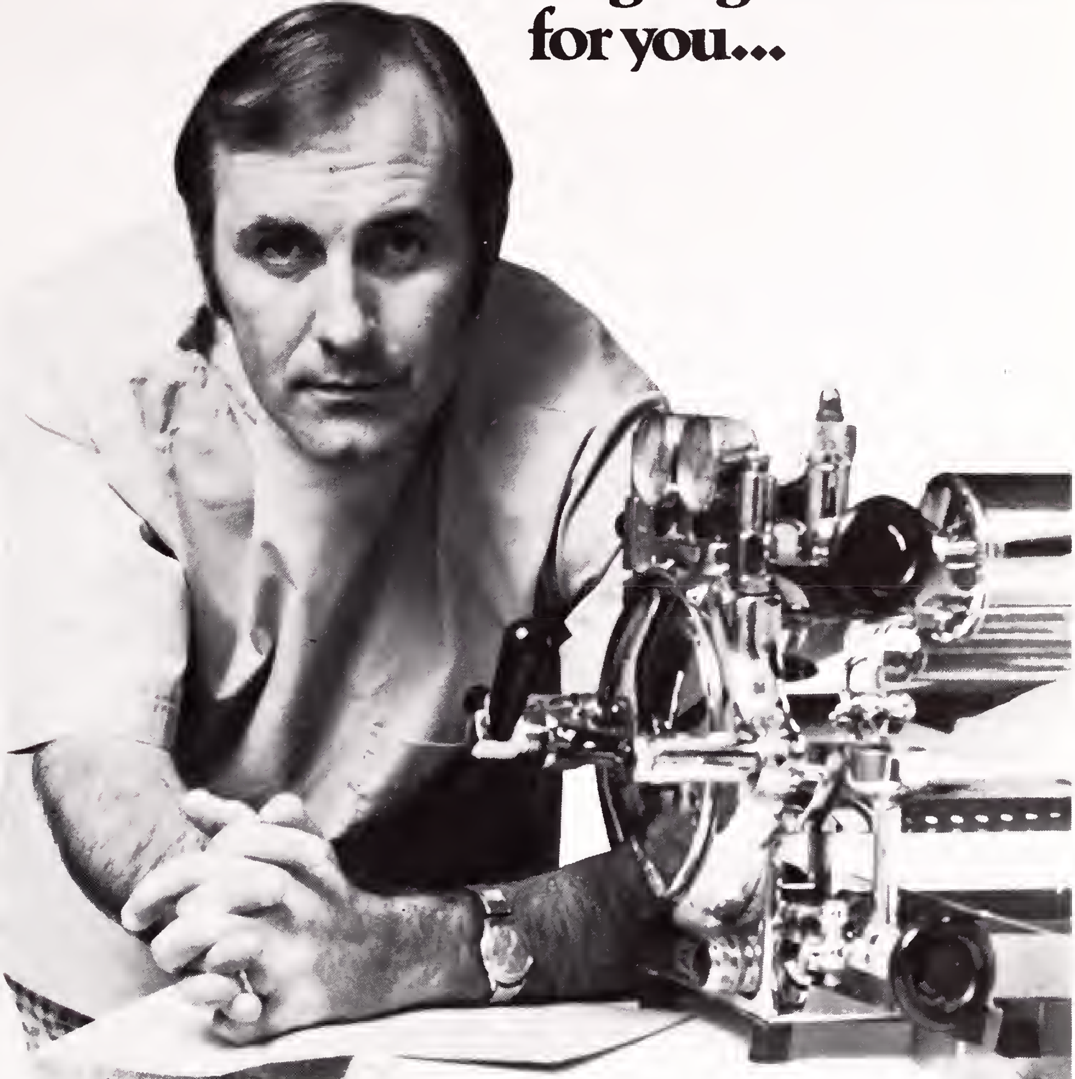

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In memoriam

Nikolas Kazmers, MD
Lakeview

Nikolas Kazmers, MD, of Lakeview, chief surgeon of Kelsey Memorial Hospital, died Oct. 5 at the age of 59. Doctor Kazmers, who recieved his medical education in Latvia, served an American internship at Butterworth Hospital in Grand Rapids before beginning his practice in Lakeview. He was a past president of the Ionia-Montcalm County Medical Society and a past chief of staff and a trustee of Kelsey Hospital.

Paul A. Koestner, MD
Kalamazoo

Paul A. Koestner, MD, a Kalamazoo physician since 1930, died Sept. 17. He was 69. Doctor Koestner was a past president of the Kalamazoo Academy of Medicine and a former chief of staff at Borgess Hospital, where he also had served as chief of obstetrics and gynecology. He was team physician for Hackett High School.

Doctor Koestner received his medical education at the University of Illinois. He served overseas during World War II.

Earle Stanley Oldham, MD
Marquette

Earle Stanley Oldham, MD, 65, of Marquette, died Sept. 23 in Rochester, Minn. Doctor Oldham was graduated from the Wayne State University School of Medicine and formerly practiced in Breckenridge. He moved to Marquette in 1965 for an association with the Northern Michigan University health services and entered private practice there the following year. Doctor Oldham, a veteran of World War II naval service, was a fellow of the American Academy of Family Physicians. He was a past president of the Gratiot-Isabella-Clare County Medical Society.

Edward Daniel Sage, MD
Kalamazoo

Edward Daniel Sage, MD, of Kalamazoo, died Oct. 20 at the age of 95. Doctor Sage was graduated from the University of Illinois College of Medicine in 1901 and practiced in Kalamazoo for more than 50 years. Doctor Sage at one time served as Kalamazoo city physician and he served as a member of the selective service board and examining physician in Kalamazoo throughout World War II. He was formerly on the staff of Borgess Hospital.

Nathan H. Schlafer, MD
Detroit

Nathan H. Schlafer, MD, a Detroit physician for more than 40 years, died Oct. 13 at the age of 72. Doctor Schlafer, a graduate of the Wayne State University School of Medicine, was chief physician for the J.L. Hudson Co. for 35 years. He also was a former chief resident surgeon for Detroit General Hospital.

Leonard F. Thalner, MD
Jackson

Leonard F. Thalner, MD, of Jackson, died Sept. 20 at the age of 78. Doctor Thalner was a graduate of the University of Michigan Medical School and had practiced as a physician and surgeon since 1919.

Doctor Thalner served at one time as Jackson city physician. He was a former chief of surgery at Mercy Hospital and a past president of the Jackson County Medical Society.

Sanford Martin Tweedie, MD
Sandusky

Sanford Martin Tweedie, MD, 73, of Sandusky, a physician and surgeon for more than 50 years, died Sept. 4 in Ann Arbor. A graduate of the Wayne State University School of Medicine, Doctor Tweedie, along with his father and brother, operated a hospital in Sandusky for 20 years. He was a fellow of the American College of Surgeons.

Doctor Tweedie was president of the Sandusky Board of Education for 14 years and also served as Sanilac County Republican Chairman. He was a veteran of World War II.

Luther H. Zick, MD
Phoenix, Ariz.

Luther H. Zick, MD, a former Lansing surgeon, died Oct. 16 in Phoenix, Ariz., where he moved in July. He was 55. In Lansing, Doctor Zick was on the staffs of St. Lawrence, Sparrow and Ingham Medical Hospitals.

He was graduated from the University of Michigan Medical School and completed residency training in surgery at St. Luke's Hospital in Chicago and a fellowship in surgery at the Mayo Clinic. Doctor Zick, an army captain during World War II, practiced in St. Joseph from 1951 until moving to Lansing in 1970.

Senate passes bill on MD licenses

New Medical Licensing Act, Generic Drugs Highlight Legislative Program

By Bruce Ambrose
Manager, MSMS
Department of
Government Relations

Senate passage of SB *547,* the MSMS-sponsored proposed new medical licensing act, gave impetus in November to the long desired revision of Michigan's 74-year-old practice act.

At the same time, activity appears about to take shape in the legislative effort to repeal the drug anti-substitution law and replace it with a limited substitution allowance.

As the Legislature entered its Thanksgiving recess, it planned on two or three more weeks of sessions before completing its 1973 work schedule. Proposals not acted upon this year will carry over into 1974.

The Senate adopted the proposal by MSMS and the Board of Registration in Medicine to completely rewrite, revise and restructure the medical licensing law of 1899 by a vote of 30 to 0. From there it went to the House of Representatives and was referred to its Committee on State Affairs.

The bill would establish the "limited license," whereby a physician whose license has been revoked or suspended may be permitted to return to practice under limitations prescribed by the board.

It would establish the "sick doctor" procedure under which a physician who is ill may be removed from practice and subsequently returned with full licensure and without prejudice.

Modifies FLEX Rules

It recognizes changes in medical education and modifies requirements for taking and passing the FLEX examination for licensure.

The bill passed by the Senate also increases the size of the state medical licensing board from ten to 11 members, with the public to be represented in the new seat. Another important change is the elimination of reference to "internship" and "residency" with reference instead to "postgraduate" training.

Wide Support

Supporting the bill with MSMS and the Board of Registration in Medicine are the State Departments of Licensing and Regulation and Public Health and the Office of Health and Medical Affairs.

Members of the House State Affairs Committee which now will consider the bill are Rep. Josephine Hunsinger, of Detroit, Chairman, and Representatives David Bonior, of Mt. Clemens; David Holmes, of Detroit; Edward Mahalak, of Romulus; John F. Markes, of Westland; Michael Novak of Detroit; Casmer Ogonowski, of Detroit; Steven Stopczynski, of Detroit; Bert Brennan, of Saginaw; John Engler, of Mt. Pleasant; Raymond Smit, of Detroit, and DeForrest Strang of Sturgis.

Drug Bills

Although two bills relative to generic drug substitution were introduced in the House early in the year, and extensive public hearings have been held by a subcommittee on consumer affairs on the bills, no specific action has been generated in the House.

HB *4145* is a straight repeal measure, which would give pharmacists license to substitute among generic equivalence and brand names for the

(Continued)

Legislative Roundup

prescription written by the physician. HB *4593* would establish a state equivalency commission to draft a drug formulary from which pharmacists could substitute. Both approaches were introduced by Rep. Joseph Forbes, of Oak Park.

The MSMS Council has adopted a position of adamant opposition to HB *4145*. It expressed opposition to the formulary approach but provided for a reconsideration as the bill is further developed. Rep. Lynn Jondahl, of East Lansing, a member of the subcommittee working on the bill, met early in the autumn with a group of general practice physicians, and is now seeking to write a substitute bill geared to assure protection of the physician's prescription prerogatives.

Governor's Opinion

Gov. Milliken, at a statewide consumers conference Oct. 13, spoke in favor of permitting generic substitutions. However, in a later message on consumer protection to the Legislature, the Governor said, "My staff and I will work with the Legislature in attempting to develop effective legislation to permit generic drug product selection. Such legislation should accomplish the following:

"1. It should acknowledge increasing evidence that chemical equivalency does not necessarily mean therapeutic equivalency as well as safeguard the professional discretion of physicians and pharmacists by assuring consultation between them before a substitution is made.

"2. It should assure that all cost savings resulting from substitution are passed on to the consumer.

"3. It should serve to strengthen, rather than weaken, competition at the point of delivery to the consumer.

"4. It should require generic labeling of prescription drugs."

New Issues

Meanwhile, a number of new issues are arising for the new session beginning in January.

Sen. Robert VanderLaan, of Grand Rapids, has introduced SB *952*, designed to provide loans to medical students much in the form proposed by the MSMS House of Delegates in session in October. The VanderLaan proposal would establish a state revolving fund from which loans up to $2,500 per year for a maximum of four years could be provided to students in Michigan's three medical schools and the College of Osteopathic Medicine at Michigan State University. Although interest would be pegged at 9 per cent, the bill provides extensive forgiveness clauses to physicians who have received the loans and subsequently practice in areas of doctor need in Michigan. Sen. VanderLaan met with the MSMS committees on state legislation and public relations Nov. 8 to review the intent of his bill.

HMO Legislation

Legislation to recognize and regulate health maintenance organizations in Michigan will be introduced shortly by Sen. William Ballenger of Lansing. The bill has been prepared by the Office of Health and Medical Affairs and bears some imprint from MSMS advice.

The intent of the bill is to establish fiscal integrity of HMOs in Michigan, by giving the insurance commissioner authority over HMO financing, and assure quality medical and health care by allowing performance audits by the Department of Public Health. In August the Council took the following position on HMO's in Michigan:

> *That MSMS support health maintenance organization legislation as proposed by the Office of Health and Medical Affairs, as an experimental method of health care without subsidy, when certain conditions are met (including 13 specific issues cited by MSMS).*

While the second draft of the HMO legislation does meet many of the MSMS citations, others are not satisfied. A subcommittee of the Legal Affairs Committee now is reviewing the second draft and will submit a report with recommendation to the Council in January.

Action also is anticipated in 1974 on a bill introduced by Sen. Anthony Stamm, of Kalamazoo, to require written warranty by licensed professionals in order to substantiate breach of contract suits (SB *809*) and a bill to be introduced soon attempting to obtain for all health care providers a uniform health insurance claim form.

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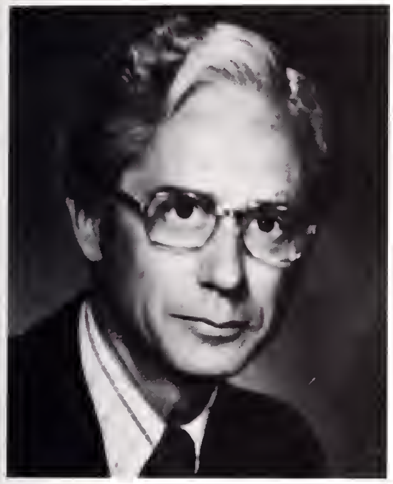
President's page



Brooker L. Masters, MD
MSMS President

Laura Jean and I have just returned from the MSMS Intrav Mediterranean Adventure, a well conducted educational experience taking us into the early roots of our civilization and a trip that every MSMS member should consider for a truly broadening experience.

Included on the tour were several medical seminars which gave an insight into the medical problems of the area. To no one's surprise, we learned that the doctors of the entire Mediterranean area have the same problems we have in Michigan: insufficient personnel, maldistribution of that personnel, burgeoning demand for services and inflation. But they have one problem we do not have as yet: socialization.

Each of the doctors who spoke to us implied or said outright that his practice was controlled or influenced by "government." It was obvious that this influence must be a restricting factor in delivery of health care. The issue was well summarized by a panel of three doctors in Turkey.

Turkey has been a pawn between East and West throughout history and has gained its independence only in this century. In fact the country was in the process of celebrating its fiftieth year of independence while we were there, and perhaps the banners and parades in observance of this festive event contributed to the dynamic feeling of the country. Public spirits were high. We had the impression that after all their kings, sultans and dictators, the people were truly rejoicing in their democratic status.

In the midst of this rejoicing, three members of the Turkish Medical Association including its president, Doctor Mustafa Severdien, spoke to those of us present on the Mediterranean Adventure. Turkey may be a democracy, but Turkish medicine is state controlled although 20 per cent of the doctors do not participate. The majority of the other 80 per cent may see private patients after 3 p. m. One wonders how this hour was arrived at. Doctors are salaried, with salaries determined by specialist-level, years of practice and so on.

When asked to comment upon the relationship between the Turkish Medical Association and the state, Doctor Severdien indicated an attitude of increasing vigilance or militancy. His words were heartfelt when he said, "Every week—every month—every year, we are trying to do what you are doing in America with your AMA."

Strange, isn't it? Here in the United States we take our form of democracy for granted while we enjoy freedom in the practice of medicine. Our medical associations do have influence on government and in our organizations we have a unified voice with which to speak against the socialization of medicine sought by some politicians. And yet there are physicians who show resistance toward the AMA and its policies while at the same time failing to come forward to actively participate in the formation of these policies. Organized medicine is our weapon against socialization, which can only mean control of the way that we practice and in all probability hinder us in providing care to our patients.

This resistance seems especially strange when medicine in countries which have become socialized is struggling to become free, to "do it the way you have it in America."

Editor's note: Doctor Masters visited Greece and prepared his comments prior to the recent overthrow of the Greek government.

Highlights of MSMS Council meeting, Nov. 7, 1973

The first meeting of the new Council was held at the MSMS Headquarters with new councilors, Benjamin Jeffries, MD, Harper Woods, and Marion G. McCall, Jr., MD, Detroit, seated for the first time.

The Council began work to implement three resolutions adopted by the fall session of the MSMS House of Delegates:

Resolution 2, re PSRO—the various "resolveds" were referred to appropriate committees. (See the Nov. 23 issue of *Medigram* for details).

Resolution 15, re Involuntary Sterilization—Referred to the MSMS Committee on Maternal and Perinatal Health for recommendations.

Resolution 22, re Task Force on Graduate Medical Education—The task force was constituted as a committee and requested to present recommendations to the Council. Several additional appointments, authorized by the resolution, will be made.

Vernon V. Bass, MD, Saginaw, Speaker, reported that he soon will appoint two committees authorized by the House, dealing with development of guidelines for comprehensive health insurance and health care of medically indigent.

Council Chairman Robert M. Leitch, MD, Battle Creek, made these appointments:

To study and report on recommendations from the Committee on Planning and Priorities—John J. Coury, MD, Port Huron; Kenneth H. Johnson, MD, Lansing; Robert C. Prophater, MD, Bay City; Robert M. Stow, MD, Lansing; Donald N. Sweeny, Jr., MD, Detroit, and Louis R. Zako, MD, Dearborn Heights.

Chairman, Education Liaison Committee—Doctor Stow.

Chairman, Publication Committee—James H. Tisdel, MD, Port Huron.

Chairman, Committee on Professional Liability—John W. Grigg, MD, Bay City.

Chairman, Committee on Group Casualty Insurance—William Marshall, MD, Kalamazoo.

Chairman, Committee on Group Life and Health Insurance—Donald Blain, MD, Mt. Clemens.

MSMS representative on Michigan Association of the Professions board—O.J. Johnson, MD, Bay City.

The Council approved plans for the MSMS Leadership Conference to be held at Weber's Inn, Ann Arbor, Wednesday, Dec. 19.

Doctor Sweeny, chairman of the MSMS delegation to the AMA, reported that four resolutions have been submitted by Michigan for the AMA meeting in December at Anaheim.

Thomas R. Berglund, MD, Portage, chairman of the MSMS Committee on Legal Affairs, gave an overview of the work of the committee and listed 18 specific "problem areas."

The Council authorized the appointment of a new Committee for the Rehabilitation of Sick Physicians after hearing an extensive report from Richard C. Bates, MD, Lansing, chairman of the MSMS Committee on Alcohol and Drug Dependency. His committee recommended such a new committee and offered tentative procedures. The final procedures are to be developed by the new committee and sent to the Council for approval.

Doctor Coury described the initial work of his special task force to develop responses to Gov. Milliken's message to the MSMS House of Delegates.

The Council voted to make no general distribution of the recently-completed MSMS study of physician fees but to make it available to MSMS members upon request at a modest charge to cover costs of printing.

The Council approved the 1974 MSMS budget, upon the recommendation of Ernest P. Griffin, MD, Flint, chairman of the MSMS finance committee. Doctor Griffin reported that "the budget has a $17,000 deficit which can be funded from the current operating fund which will wind up with a slight growth for 1973." He added that all MSMS costs have increased slightly over the last year and that the "proposed total expense for 1974 will be 3.4 percent over the 1973 budgeted expenses."

The Council voted to "express its deep interest in the Governor's proposals to establish a Department of Human Services by combining the Departments of Social Services, Public Health and Mental Health along with several smaller agencies and express MSMS's willingness to provide input into development of the new department concerning matters about which physicians are

(Continued)

About 175 medical chiefs of staff, hospital administrators and hospital board members participated recently in a Michigan State Medical Society—Michigan Hospital Association sponsored "Workshop on Accreditation Problems" in Ann Arbor. Conference leaders were (left to right) Karl S. Klicka, MD, Wayne, moderator; Sister Gertrude Bastnagel, Southfield, president of MHA, and Donald L. Kessler, MD, of the Joint Commission on Accreditation of Hospitals staff, Chicago.

Medical schools report progress in plans to train family physicians

Expanded training of family physicians at the Wayne State University School of Medicine and Michigan State University's College of Human Medicine is in the offing as a result of recent action by the boards of the two institutions.

The Wayne State Board of Governors on Nov. 9 heard a report from President George E. Gullen, Jr., on establishment of a Department of Family Medicine at Wayne and approved leasing of 21,645 square feet in the old nursing residence at Harper Hospital for training of resident physicians and medical students. The newly leased space will be part of the university's Family Health Service which is to begin operation Jan. 1.

Dwight M. Schroeder, MD, a family physician in Northport since 1958, has joined the Wayne family medicine faculty, and two more full-time family physicians are to be added Jan. 1. A total of nine family physicians will staff the family medicine program by July 1, 1974, according to Robert D. Coye, MD, dean of the WSU School of Medicine.

The MSU board of trustees on Oct. 26 gave approval for the establishment of a new Department of Family Medicine at the school's College of Human Medicine. Andrew D. Hunt, Jr., MD, dean of the college, said that the new department would cost $645,000 and that the Kellogg Foundation would share the cost through 1980.

Dean Hunt said that eight new faculty members would be added for the new department. The College of Human Medicine has been conducting a search for a chairman for the Department of Family Medicine, but selection of a physician for the post has not yet been announced.

MSMS COUNCIL/Continued

uniquely knowledgeable." The Legal Affairs Committee was asked to study HB 5345 re this matter.

Council members discussed MSMS objectives for 1974 and Doctor Leitch appointed Brock E. Brush, MD, president-elect, chairman and Doctors Prophater and Zako to consolidate opinions and to present recommendations for consideration at the December meeting of the Council. The list of nine preliminary priorities will be sent to all MSMS members within several weeks with requests that they rank the projects.

A motion was adopted that the chairman appoint a committee to consider the development of a "Physician's Bill of Rights."

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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A special report on proposed revision in Michigan's medical licensing act and other measures of importance to physicians before the state legislature begins on page 817.

The cover, designed by Marvin Pearson, Lansing, features a winter photograph of Michigan's capitol.

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Zip code 48823

Physician suggests system for helping newcomers find doctors

To the Editor

After a fair number of my patients have reported great difficulty in finding a physician who will accept them when they move to Southern Michigan cities, I have a suggestion to make.

Could not hospital switchboard operators have lists of staff-connected generalists, internists and pediatricians who will still accept new patients? Then receptionists of physicians who cannot accept new patients could refer calls to the hospitals instead of just turning the request down.

This would probably require local medical society action, but I think this problem merits attention. The news spread around to the families and friends of new arrivals who can't find a doctor with relative ease is excellent ammunition for the supporters of a Kennedy-type National Health Insurance.

Respectfully,

John R. Rodger, MD
Bellaire, Mich.

INFORMATION FOR CONTRIBUTORS

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3. Illustrations should be submitted in the form of glossy prints or original sketches from which reproductions will be made by **Michigan Medicine.**

4. Articles should ordinarily be less than four printed pages in length (3000 words).

5. References should conform to *Cumulative Index Medicus,* including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.

6. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.

7. It is understood that material is submitted for exclusive publication in **Michigan Medicine.**

8. Letters and articles for the news section should be sent to the Managing Editor, **Michigan Medicine,** 120 W. Saginaw, East Lansing, 48823, by the fifth of the month preceding the month of publication.

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Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.
Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.
Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.
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The Weight of Professional Opinion

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These professional and trade organizations are united in supporting antisubstitution statutes and regulations

The American Academy of Dermatology

The Board of Directors of the American Academy of Family Physicians

The Executive Board of the American Academy of Neurology

The Committee on Drugs of the American Academy of Pediatrics

The American College of Allergists

The Executive Committee of the American College of Obstetricians and Gynecologists

The Board of Regents of the American College of Physicians

The Board of Trustees of the American Dental Association

The Board of Trustees of the American Medical Association

The American Psychiatric Associat

The Executive Committee of the National Association of Retail Druggists

The Board of Directors of the Pharmaceutical Manufacturers Association

The National Wholesale Druggists' Association

Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such aws and regulations encourage interprofessional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

Placidyl®
(ETHCHLORVYNOL)
Brief Summary

Indications—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

Contraindications—Drug hypersensitivity and porphyria.

Warnings—Not recommended during the first and second trimester of pregnancy. Caution patients of possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

Precautions—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitryptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

Adverse Reactions—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 304431

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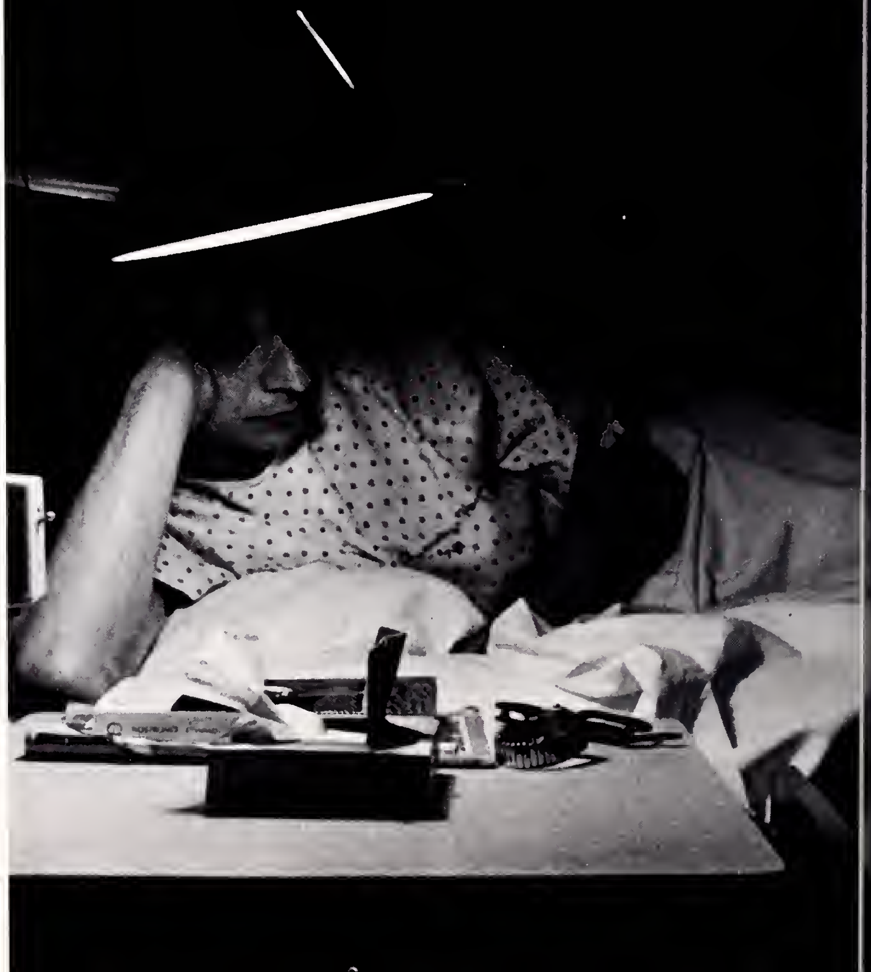


Michigan mediscene

Dec. 19—MSMS Leadership Conference, Weber's Inn, Ann Arbor, contact: Herbert A. Auer, MSMS Headquarters.

Jan. 15, 1974—Midwinter board meeting, MSMS Auxiliary, at MSMS headquarters, East Lansing, contact: Mrs. William J. Jones, president, 15839 Crescent Dr., Allen Park, Mich. 48101.

Jan. 16, 1974—Lecture on acupuncture by William M. Lukash, MD, White House physician, sponsored by William Beaumont Hospital Research Institute, at the hospital in Royal Oak, contact: Research Institute, Beaumont Hospital, 3601 W. 13 Mi. Rd., Royal Oak, Mich. 48072.

Jan. 23, 1974—MSMS Council, MSMS headquarters, contact: Warren F. Tryloff.

Jan. 25-26, 1974—Postgraduate education course on "Colon Disease & Colonoscopy," offered by the Medical College of Wisconsin departments of gastroenterology and surgery, at Milwaukee's Pfister Hotel, contact: Joseph E. Geenen, MD, 8700 W. Wisconsin Ave., Milwaukee, Wis. 53226.

Feb. 21-24, 1974—Seminar and ski weekend arranged by the Continuing Post Graduate Phychiatric Education Program at Wayne State University, at Shanty Creek Lodge, Bellaire, for physicians and spouses, contact: Leon E.A. Berman, MD, Detroit Psychiatric Institute, 1151 Taylor Ave., Rm. 151 B, Detroit, Mich. 48202.

March 7, 1974—Professional Activity Study and Medical Audit Program Institute, sponsored by Commission on Professional and Hospital Activities, at CPHA headquarters, Ann Arbor, AAFP elective hours, contact: CPHA, 1968 Green Rd., Ann Arbor, Mich. 48105.

March 15-16, 1974—Second Annual National Conference on Human Nutritional Aspects of Kidney Disease and Renal Failure sponsored by the Kidney Foundation of Michigan, Michigan Renal Dietitians and the Michigan State University School of Nutrition, at Kellogg Center, MSU, East Lansing, contact: Ms. Jean Bruge, Michigan Nephrology Center, Borgess Hospital, 1521 Gull Rd., Kalamazoo, Mich. 49001.

March 18-21, 1974—Physician postgraduate course "Rheumatic Disease: Pathogenesis, Diagnosis and Treatment," sponsored by American College of Physicians, at U-M Medical Center, Ann Arbor, contact: ACP, 4200 Pine St., Philadelphia, 19104.

March 18-23, 1974—Continuing education course in laryngology and bronchoesophagology, sponsored by the Department of Otolaryngology, Abraham Lincoln School of Medicine, University of Illinois, and the Eye and Ear Infirmary, U of I Hospital, in Chicago, contact: Dept. of Otolaryngology, Eye and Ear Infirmary, 1855 W. Taylor St., Chicago, Ill. 60612.

March 27-28, 1974—Annual Michigan Conference on Maternal and Perinatal Health, the Pantlind Hotel, Grand Rapids, contact: Lloyd Kammeraad, MD, 1810 Wealthy St., SE, Grand Rapids, Mich. 49506, or Helen Schulte, MSMS Headquarters.

April 4, 1974—Ninth Annual Conference on the Medical Aspects of High School Sports, sponsored by MSMS, at Towsley Center, U-M, Ann Arbor, contact: Helen Schulte, MSMS Headquarters.

April 24, 1974—Annual Legislative Day, MSMS Auxiliary, at Olds Plaza Hotel, Lansing, contact: Mrs. Robert J. Westerhoff, 2458 Maplewood, SE, Grand Rapids, Mich. 49506.

April 24-25, 1974—Annual Spring Conference, MSMS Auxiliary, at Hospitality Inn, Lansing, contact: Mrs. William J. Jones, president, 15839 Crescent Drive, Allen Park, Mich. 48101.

April 25-27, 1974—27th National Conference on Rural Health sponsored by the AMA Council on Rural Health at the Detroit Hilton Hotel, contact: Bond L. Bible, PhD, Department of Rural Health, AMA, 535 N. Dearborn St., Chicago, Ill. 60610.

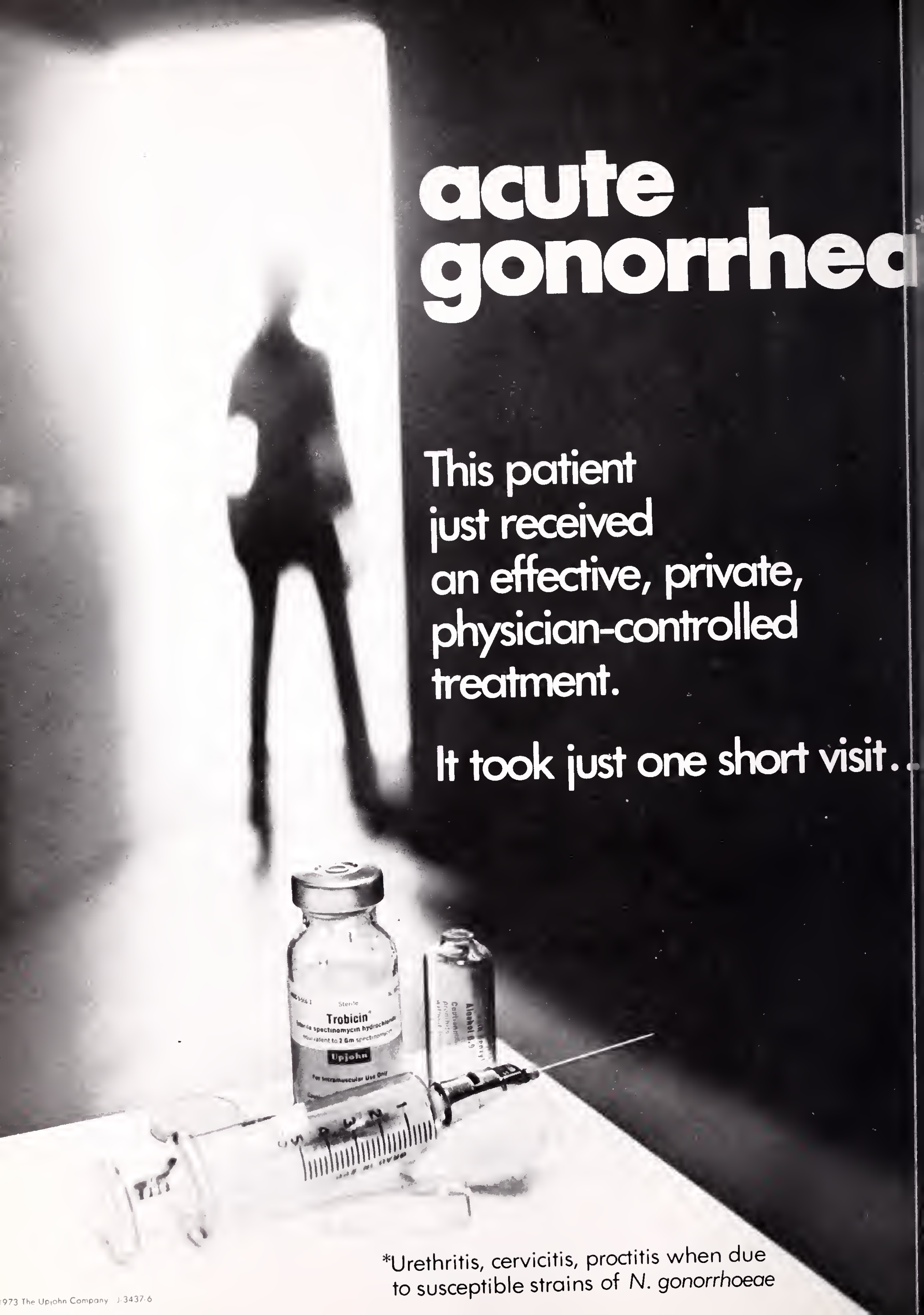
May 1-3, 1974—Annual meeting of the Michigan Public Health Association, Detroit Hilton, contact: Anna Lampela, MPHA, 403 Seymour Ave., Lansing, Mich. 48914.

May 5-7, 1974—1974 Annual Session, MSMS House of Delegates, at Boyne Mountain, contact: Richard Campau, MSMS Headquarters.

May 9-10, 1974—Seventeenth Annual Clinic Days of Children's Hospital of Michigan, postgraduate meeting on pediatric infectious diseases, cosponsored by the Wayne State University School of Medicine, contact: Adnan Dajani, MD, Children's Hospital of Michigan, Detroit Medical Center, 3901 Beaubien Blvd., Detroit, Mich. 48201.

May 24-25, 1974—13th Annual Kidney Disease Symposium sponsored by the Kidney Foundation of Michigan at Henry Ford Hospital, Detroit, contact: Kidney Foundation of Michigan, 3378 Washtenaw Ave., Ann Arbor, Mich. 48104.

Michigan Mediscene each month lists upcoming meetings in Michigan or, if out of state, of special interest to Michigan physicians. Please submit meeting notices for listing at least two months prior to meeting dates to **Michigan Medicine**, 120 W. Saginaw St., East Lansing, Mich. 48823.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*Urethritis, cervicitis, proctitis when due
to susceptible strains of *N. gonorrhoeae*

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Trobicin—The aspect of privacy.
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Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly[†]; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic. Trobicin is contraindicated in patients previously found hypersensitive to it.

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An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.

Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.

Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.

During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.

Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.

Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.

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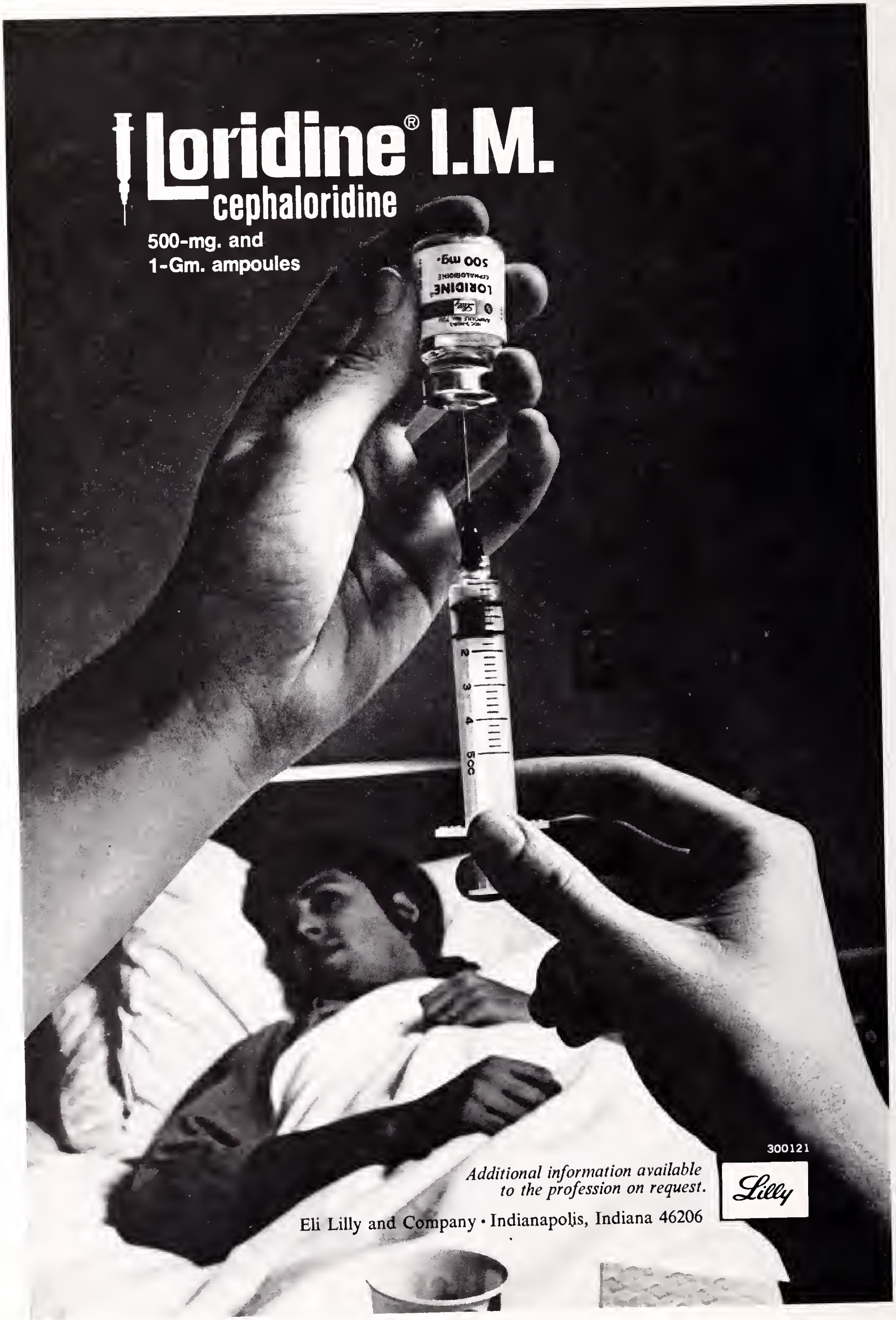
The Upjohn Company, Kalamazoo, Michigan 49001

[†] For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.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Humanistic aspects of psychopharmacological care of the terminal cancer patient

By Bruce L. Danto, MD
Detroit

This paper deals with discussion at a workshop on "Humanistic Aspects of the Use of Psychopharmacologic Agents in the Care of the Dying Patient and the Bereaved" at a meeting of the Foundation of Thanatology held at the Columbia University College of Physicians and Surgeons. It was felt by the author that his expansion of the notes of that meeting could offer both the medical student and experienced physician a guideline for the care of the terminal patient.

Those members in attendance expressed agreement that lesion odors often cause an isolation of the patient. It was suggested that many lesions, particularly oral ones, can be irrigated with potassium permanganate. The effect of such a procedure is a reduction in the mal odor of the lesion. Once the latter is accomplished, the patient can achieve greater self-respect. Further, greater comfort may be achieved because potassium permanganate offers some analgesic properties.

Despite the fact that most terminally ill patients are ignorant of the technical aspects of any medical or psychopharmacologic treatment, all members present agreed that the patient must be encouraged by hospital staff to become a participating member of the treatment team. He should be urged to keep notes on the various tranquilizing and analgesic medications he receives. He can record the dosage level and the subjective effect and can share his observations with the staff. In a similar fashion, the patient must be encouraged to function as a participating member of his family regarding important decisions like whether or not he should be told his diagnosis and prognosis, plans concerning the survivors like the children, how the financial future of the family in terms of estate planning will be directed and how he and his family will spend the remainder of their life together. The terminal patient can play an important and perhaps even crucial role in making it possible for his loved ones to work through their feelings of guilt about their relationship in terms of hurts, conflicts, resentments and areas of fulfillment insufficiency. In this context, his death becomes a part of their living experience as much as any other major experience to be shared to whatever extent possible.

The participants at the meeting dealt with philosophical views which, at first, appeared to be in opposition. It seemed as though technological intervention was opposed to humanistic termination of life or at least permitting the patient to decide how long intervention should be continued. Medical responsibility traditionally has supported the view that the physician must maintain life until all efforts fail. Aside from this clear-cut position, it was felt that the two views can reach areas of agreement. For example, the use of psychopharmacological agents is both technological as well as humanistic intervention. The same can be said of other palliative measures like analgesics and various surgical procedures like cordotomy. Thus, medication can be employed to enhance patient comfort. It does not necessarily interfere with efforts undertaken to assist the patient and his family to work through their feelings about and approach to his death. The patient can still utilize the technological intervention so that he can "grab onto" a relationship with others to help him come to terms with his condition and future.

In addition to the important question concerning such a patient's right to participate in treatment decisions was that of his right to decide whether or not he wants to live or commit suicide. It was felt by all in attendance that one cannot apply the right of patients to the question con-

(Continued)

Doctor Danto is director of the Suicide Prevention and Drug Information Center at the Detroit Psychiatric Institute and an associate professor in the Department of Psychiatry at the Wayne State University School of Medicine. He is the author of ***Jail House Blues,*** recently published by Epic Publications, Inc., Orchard Lake.

cerning the right to commit suicide as they're not the same thing. Furthermore, this author takes the view that the patient may not be aware of the value his life may have for him as well as his family. His anticipated death may offer him an opportunity to play one of the most important roles of his life as regards the survivors and their need for his help to prepare for his death, work through their guilt feelings, make plans for the future, etc. This moment might well be his most significant one. Suicide would not only rob him of that experience but it would also add more guilt feelings to the survivors and leave them with less dignity and less memory of his courage and will to make his life a meaningful experience to all concerned.

Clarified was the fact that intervention in the terminal state is really not possible. Support of the patient is a more realistic approach and goal. As such, therefore, the combined approach of various psychopharmacologic agents and a humanistic psychological approach is the only sensible plan. One of the major problems in bringing about the combined approach is the void of appropriate personnel. In most hospitals, psychiatric consultations take a long time ordinarily. Many specialists would be tempted to feel that cancer or terminal patients are not high priority for such attention. Some physicians would be the worst type person, personality-wise, to inform the patient and work with him toward his acceptance of his terminal state. An ideal approach would be the development of a "death team," much on the basis of the type developed at St. Christopher's Hospice in London, England. On this team could serve those trained in social work, psychology, nursing and the ministry as they all have much experience and knowledge which could be used most effectively. For example, Catholic priests at Physicians and Surgeons Hospital, Columbia University, do not administer Last Rights to patients on the Cancer Service. Rather, they offer a prayer for the sick which they administer while the patient is alive and conscious. Normally, when a priest calls on a patient, the family becomes frightened that all hope is gone and they are attempting to change the role so as to serve as a source of comfort rather than a sign of "the end." In point of fact, a strong religious orientation can enable a patient to show less anxiety about his future from a terminal state. For example, he can conceive of an after-life, a reunion fantasy with deceased loved ones, children and accomplishments as his monuments and perhaps an elaborate funeral replete with a coffin with a trigger mechanism so that he can release the lid in the event he is still alive. Such "plans" enable a patient to deny his death. In essence, he feels that he changes his address but does not cease to live both psychologically and philosophically. The basic concept of survival and immortality is further enhanced through religious ceremonies and beliefs of naming children after the dead and holding annual death services for loved ones who died.

The terminal state of a child elicits more sympathy as we view him as being more helpless and an adult more self-sufficient and having "lived and had a chance to make it in life." Further, it is easier to communicate with an adult and as such it can be easier to make his death more meaningful to him than a child. For those of us who treat the dying patient, the fact that we can't or don't have to talk to a child makes it easier for us as we don't have to handle embarrassing questions or ones which cause us to feel uncomfortable.

Some dying patients wish to be "bombed out" psychopharmacologically but others want to be as alive, alert and aware as possible. They prefer an active mind to the end like Sigmund Freud. In terms of request for medication, therefore, doctors must take care to insure that their patients are not trying to manipulate them. Medication of the psychopharmacological type cannot help the patient structure and image of "self" in terms of death. The medical staff must exert enough effort to get to know the patient well enough so it can help him achieve his own sense of self. The sense of self he achieves must be the one he prefers, one which may not elicit approval of others. He may want to achieve a sense of unity with the cosmos as reported by those who treat the dying with Heroin and particularly LSD. On the other hand, the patient may prefer to participate in his death fully on a reality basis with his friends, loved ones and the world in general.

Care should be taken as regards the choice of "piped in" music which is played throughout the hospital, particularly for the terminal cancer patient. Some of the music may sound and be snobbish in terms of the tastes of the average person. Hospital paging noises may be frightening and disquieting to the patient in terms of stat-calls and monotonous paging of personnel. Daily prayers over the piped-in system may sound more like a preliminary to a funeral service than an offering of hope and faith.

How do we inform the patient of his diagnosis? We have to know the patient in terms of his life style and history and personality structure before we tell him. Ancillary personnel can be helpful here as they get to know the patient from many different points of view and can help to establish the needed information. Certainly, there is agreement that every patient who wishes to be informed should be told. It could be appropriate to supply such information at the outset if he chooses to be informed. As he comes to terms with his condition, self-image or sense of future more comfortably, he can assist his relatives and his doctor to achieve an

(Continued on page 839)

A wild rice seed was lodged in the superior conjunctival fornix of a 19-year-old man for 14 months and caused continuous redness and irritation. Several physicians examined the eye and failed to find the seed. Finally, the seed was discovered by simple eversion of the upper lid. Histological study showed much effect of the cells and secretions of the conjunctival sac on the inner structures of the seed while its outer shell was rather well preserved. The present case shows the importance of eversion of the upper lid as part of a complete examination of irritated eyes.

A wild rice seed under the upper eyelid: Found after 14 months by eversion

By J. Reimer Wolter, MD
Ann Arbor
Norman P. Peterson, MD
Duluth, Minn.

Under the upper eyelid the conjunctiva forms a deep recess known as the superior fornix. Foreign bodies have a tendency to lodge in this superior fornix. Only with everting—or even doubly everting the upper lid while the patient looks down is it possible to inspect the superior fornix. Every ophthalmologist knows of instances where a chronically red, tearing and painful eye was, finally, explained by an unsuspected foreign body in the superior fornix. The list of foreign bodies found there commonly includes insects or the patient's own contact lens that was thought lost on the floor. It is well known that smooth foreign bodies in the superior fornix cause relatively few symptoms. Irregular objects soon become covered by a rather dense layer of smooth mucus and are, thus, also well tolerated.

The present case is reported to show for how long a large foreign body can remain in the superior fornix as a source of constant irritation and for how long it can escape discovery and removal by physicians who do not routinely check the fornices in the eyes that have been exposed to foreign matter as well as in all chronically irritated eyes.

Case Report

This 19-year-old airman was first seen in November, 1972, in The Duluth Clinic for a chronically irritated and painful left eye. The patient stated that he had been "wild ricing" with a canoe 14 months before. Wild rice is a crop grown in Minnesota and is cultivated primarily by Indians, but whites, on occasion, also take part in the cultivating and harvesting of wild rice. During this occupation 14 months ago the patient felt something go into his left eye. He saw a local doctor who examined his left eye and told the patient that he extracted most of the material that he had in his eye. However, the patient continued to have non-specific problems with the left eye, such as variable soreness, redness, secretion and slight pain. The pain was worst when the patient looked up and to the left. The patient went to see several other doctors within the 14 months, but no one was able to solve the problem.

Figure 1. Gross view of the wild rice seed removed from the upper fornix of the present patient. The seed was 24 mm long. —photograph x 5.

Our examination in November, 1972, revealed the patient's vision to be 20/20 and J 0 in both eyes. External examination and slit lamp study showed conjunctival injection that was most severe in the upper conjunctiva as well as an early superior pannus of the left cornea. There was no corneal staining, however, and the anterior chamber, iris, lens and vitreous of the left eye were normal. The left upper eyelid was everted and papillomatous conjunctivitis was observed on the tarsal conjunctiva. The patient was asked to look down and a brown object was seen to be lodged deep in the upper conjunctival fornix. With forceps this brown object was easily extracted from the upper cal-de-sac. Inspection revealed this to be a well preserved wild rice seed in the husk *(Figure 1).*

(Continued)

From the Departments of Ophthalmology and Pathology of the University of Michigan Medical Center. Supported by the Research to Prevent Blindness, Inc., New York, N.Y. For reprint requests please write to: J. Reimer Wolter, MD, Department of Ophthalmology, University of Michigan Medical Center, Ann Arbor, Michigan 48104.

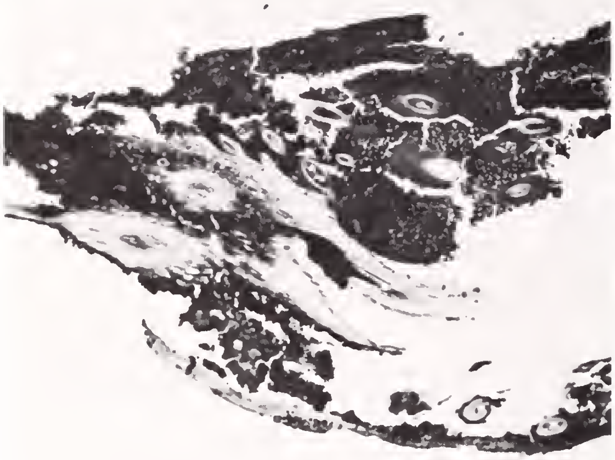

Figure 2a. Microscopic view of a part of a section of the seed showing partly digested seed structures filled with exudate and a dense cellular infiltrate.

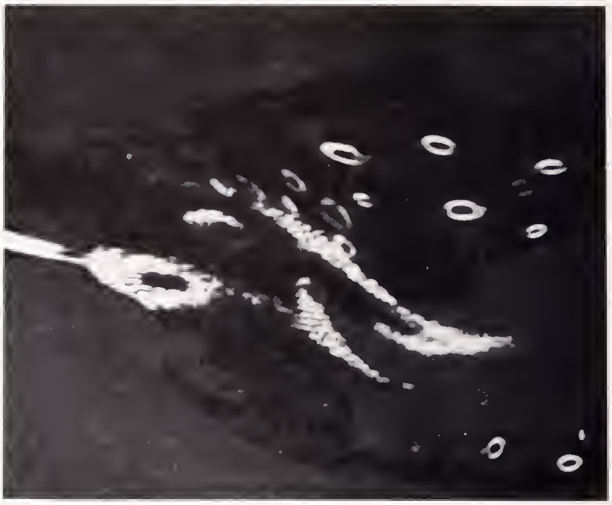

Figure 2b. Polarized light shows the structures of the seed and its husk in the same section against a dark background. —paraffin section, H and E stain, photomicrograph x 50.

Further examination revealed no additional eye problems. With the removal of the seed the patient was cured.

The wild rice seed measured 24 x 2 x 2 mm and grossly it appeared to be very well preserved *(Figure 1)*. It was, obviously, still in its husk. The seed was embedded in paraffin and histological sections were cut off it. These were stained with Hematoxylin and Eosin.

The histological sections showed that much of the inner substance of the seed had been dissolved and was replaced by an exudate containing densely packed PMN's and histiocytes *(Figure 2a)*. With polarized light[1] the structures of the seed could easily be differentiated from the exudate and the cellular infiltrate *(Figure 2b)*.

Discussion

All medical doctors should know that foreign bodies may lodge under the upper lid and cause relatively few symptoms except for chronic irritation, secretion and discomfort. The routine examination of chronically irritated eyes should, thus, include eversion or double eversion of the upper lid for inspection of the superior conjunctival fornix. In most patients this can be done without the use of topical anesthesia if the patient looks down. The present case shows that a large foreign body under the upper eyelid can remain undiscovered if this simple step in a complete eye examination is missed.

The histological study in the present case reveals interesting facts about the nature and the effect of the free cells in the upper fornix. It seems that these cells did extensive damage to the inner husk, however, were extremely well preserved after 14 months in the secretions and cells of the conjunctiva.

To evert an upper lid the patient must relax and look down. This, in turn, relaxes the levator muscle which is attached to the upper border of the tarsal plate. The patient must not squeeze the lids shut since contraction of the orbicularis muscle prevents the eversion. The physician should grasp the upper eyelashes and, at the same time, he pushes down on the upper tarsal border with the stick of an applicator. This pushing down on the tarsus while holding the lashes causes eversion. The applicator stick is removed, a finger is used to hold the lid in its everted position and a large portion of the upper fornix can, thus, be inspected. In some patients double eversion is necessary for complete evaluation of the upper fornix. A topical anesthetic is necessary for this and this is done by lifting the exposed upper tarsal border in its everted position with the finger tip. To restore the everted or doubly everted upper lid to its normal position the patient is asked to look up while the physician holds on to the eyelashes and pulls gently forward. With this the lid falls back into its normal place.

It is hoped that the lesson of the present case will serve many of us not to omit eversion of the upper lid as an important step in the examination of irritated eyes.

Reference

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An unusual case of esophagitis

By John R. Kirkpatrick, MD
Yvan J. Silva, MD
Juan Belamaric, MD
Detroit

Since Barrett's original paper in 1950, multiple cases[1,2,3] have been reported documenting the occurrence of columnar lined epithelium in the distal esophagus. From this experience, a definite clinical syndrome has evolved. A recent case at the Detroit General Hospital reemphasizes this and also points out certain management problems not previously reported.

Case Report

E. H. (#765986), a 53-year-old white male was admitted to the Detroit General Hospital with an upper gastrointestinal hemorrhage which required transfusion of four units of blood to restore his blood volume. The bleeding subsided with nasogastric suction, sedation, and antispasmodic drugs. A barium swallow *(Figure 1)* revealed a duodenal ulcer and possible esophageal varices. The patient denied alcoholic excesses and demonstrated no physical signs of cirrhosis. Laboratory studies, including liver function tests, coagulation profile, and renal function studies were all normal. Over-night gastric secretion was 600 cc with free acid of 40 mEq/L.

After the barium swallow, esophagogastroscopy was performed twice. On both examinations, the endoscopist reported no evidence of varices or reflux; esophageal mobility studies were also performed and revealed an intact functioning distal esophageal sphincter.

Because of his age, chronic symptoms, severe hemorrhage and lack of varices, he was considered a candidate for surgical correction of his duodenal ulcer. The presence of an intact cardioesophageal sphincter and the lack of a demonstrable hiatus hernia or esophageal reflux were felt to be sufficient reasons not to perform a fundoplasty. At surgery, the esophagus was mobilized to perform a truncal vagotomy; during this maneuver, virtual transection of the esophagus occurred. The incision was extended into the left chest and an esophagogastrectomy and pyloroplasty were performed. The patient had an uneventful recovery and was discharged on the twelfth postoperative day.

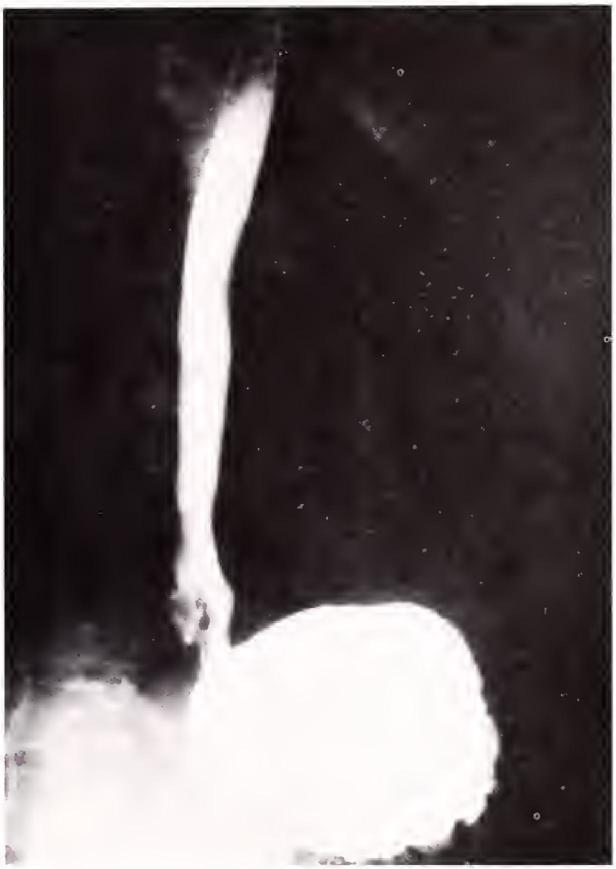

Figure 1. Preoperative barium swallow which reveals "esophageal varices."

Subsequently, the patient developed an anastomotic stricture *(Figure 2)* which responded to weekly dilatations with mercury bougies. He is symptom-free and eating solid foods eight months after surgery.

Pathology

The resected specimen consisted of an 8 cm segment of distal esophagus and a 6 cm rim of adjacent gastric wall. At the line of resection, the esophageal wall was firm and measured 1.0 cm in

(Continued)

From the Department of Surgery and the Department of Pathology, Wayne State University School of Medicine, Detroit, and Detroit General Hospital.

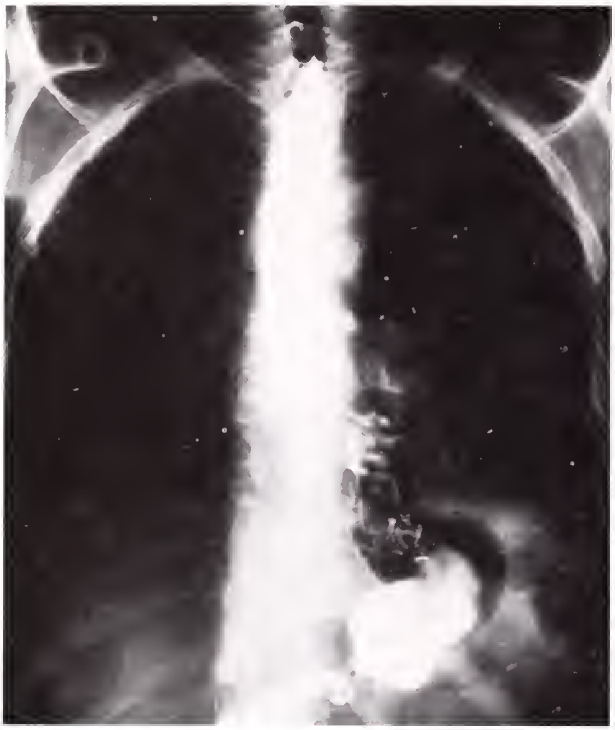

Figure 2. Post-operative (3 months) barium swallow which demonstrates anastomotic stricture and intrathoracic location of upper one-third of stomach.

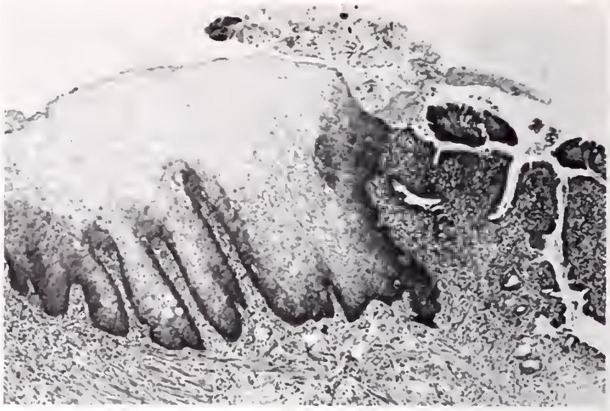

Figure 3. Junction of stratified squamous and columnar epithelium high within the esophagus, just below the esophageal line of resection. (H and E X 75)

thickness. Distally, it measured 0.5 cm in thickness. The rim of gastric tissue showed no gross abnormalities. The usual abrupt transition from gastric to esophageal mucosa was absent and gastric-type mucosa extended upward into the esophageal segment. At the esophageal line of resection, the mucosa was superficially eroded and covered by gray-yellow exudate.

Microscopically, most of the specimen was lined by a tall, simple columnar, mucus-producing epithelium, which extended from the stomach into the esophagus. In some areas, this columnar epithelium reached to the line of resection while in others, it ended near it by abutting on stratified squamous epithelium. Often associated with the columnar epithelium was a glandular element resembling glands of the cardiac portion of the stomach. Parietal and chief cells were absent. Goblet cells were not seen. In one area, an island of stratified squamous epithelium bordered proximally and distally by columnar epithelium was observed *(Figure 3)*. Except for slight basal cell hyperplasia and edema, there were no significant abnormalities in this squamous epithelial island. At the proximal line of resection, a chronic transmural ulcer was seen *(Figure 4)*. Its bed was covered by a layer of polymorphonuclear leucocytes and debris resting on granulation tissue. Deep within the wall a 0.8 cm defect in the muscularis was filled with dense scar tissue containing a few thick-walled sclerotic blood vessels with narrow lumens. Aggregates of lymphocytes and plasma cells were found within and adjacent to the scar tissue. Similar cells were present around groups of ganglion cells in the Auerbach's plexus near the ulcer. Neuromal degeneration or obvious neural loss were not, however, detected in these areas. Except for an occasional cytically dilated gland no abnormalities were observed in the cardiac portion of the gastric mucosa. The fundal mucosa had a normal complement of parietal and chief cells and only a few chronic inflammatory cells were seen in the lamina propria.

Discussion

Recognition of Barrett's esophagus clinically can often be difficult. The presence of a discrete esophageal ulcer or stricture on barium swallow with normal esophagus distal to the lesion is pathonominic of the condition.[4] Cases occur, however, where this finding is not seen.[5] In this situation, symptoms of esophagitis or a hiatus hernia usually occur. Rarely, as in our case, few of these findings will be present. The presence of esophagitis in a patient without reflux or a hiatus hernia and with normal manometric studies, should alert the clinician to the possibility of a Barrett's esophagus. Since duodenal ulcers may be seen in these same patients, it is important to establish the exact cause of the esophagitis prior to surgical therapy of the duodenal ulcer.

Failure to follow this dictum can lead to disaster. Mobilization of an inflamed Barrett's esophagus is hazardous and may lead to perforation or transection. Correction of this intra-operative complication is a formidable task, since the friable, inflamed esophagus does not lend itself to simple repair or fundic plication. As in our case, resection is ofen required to save the patient's life. However, since esophagogastrectomy is not a corrective operation for this disease, these patients often continue to have bouts of recurrent esophagitis.

It is emphasized that the presence of esophagitis without evidence of reflux or hiatus hernia should raise the possibility of a Barrett's esophagus. The presence of an intact, functioning distal esophageal sphincter in this situation lends further support to the diagnosis.[6] It is important to confirm this diagnosis by biopsy prior to any gastric surgery. Microscopic confirmation of a Barrett's esophagus where no evidence of reflux or a hiatus hernia exists should alert the surgeon that correction of other intra-abdominal pathology should be accomplished without mobilization of the esophagus if at all possible.

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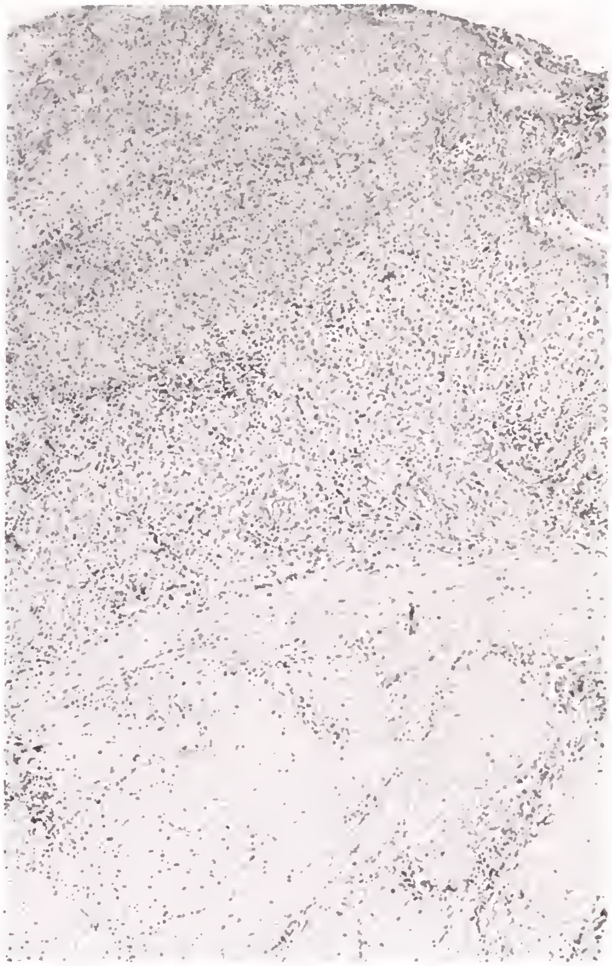

Figure 4. Transmural chronic esophageal ulcer. A layer of granulation tissue separates necrotic debris from scar. (H and E X 75).

PSYCHOPHARMACOLOGICAL CARE/Continued

acceptance of his illness and fate. He can feel trust toward his healers as he has time to measure the extent of their helpfulness, e.g., analgesia, aids to breathing, movements and function. The policy decision to be informed should be left to the patient, but it might be helpful to ask the patient why he isn't asking questions about his diagnosis and illness future if such is the case. The member of the treatment team who has the best rapport with the patient can handle the assignment of informing him. The members of the treatment team should have the option to defer to other members of the team to handle the emotional needs and issues with the patient.

What about the family? What do we do when the family forbids us from informing the patient of his diagnosis? We must make arrangements to work with the family to assist it with feelings about the diagnosis and future of its loved one. Ancillary personnel like social workers, the clergy, and psychologists can be of much help in this area and their effective use may help the family recognize why the patient should be told.

Thus, humanism as it is used in this discussion involves qualities of freedom, proximity to others and the responsibility we have to give companionship to others who are in pain and fear.

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U-M dean tells of progress against VD in Red China

The importance of motivation in public health programs, particularly toward eradication of venereal disease, in the People's Republic of China, was cited by Myron E. Wegman, MD, dean of the University of Michigan's School of Public Health, as he reported on his summer visit to China.

Doctor Wegman and 11 other medical professionals spent three weeks touring China under the auspices of the Committee on Scholarly Communication. He said that the "dedication and motivation" that he observed in Chinese cities have a "direct effect on the success of health programs which are so dependent on personal participation."

Doctor Wegman

One example of how motivation favors the fight against disease is the campaign China undertook in the early 1950's to eradicate venereal disease, Doctor Wegman noted. Using political slogans such as "We cannot take venereal disease into socialism," a two-part program was planned and aimed at both the country's extensive system of prostitution and at syphilis in the population at large.

"In a strategically-organized, simultaneous attack, the brothels were closed and the prostitutes treated, re-educated and given jobs so they would not have to return to prostitution," Doctor Wegman said. "On the other front, in view of limited facilities for mass serological testing of the entire population, they developed a simple questionnaire and organized propaganda motivation to go with it."

Those whose responses suggested possible disease were given blood tests and, if necessary, treatment. With this combined program, the chain of disease transmission was broken, Doctor Wegman said.

"They say, 'eradicated,' but I won't accept that without more evidence that the disease is really gone," he added. "However, it must be pretty rare since they say they don't even teach medical students about venereal disease anymore."

MONTHLY SURVEILLANCE REPORT

CASES OF CERTAIN DISEASES
REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH
For the five-week period ending Nov. 2, 1973

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

	1973 This 5-Week Period	1972 Same 5-Week Period	1973 Total To Above Date	1972 Total Same Date	Total Cases for 1972
Rubella	39	55	1,888	1,335	1,460
Cong. Rubella Syndrome	0	1	1	1	1
Measles	47	68	4,425	2,061	2,353
Whooping Cough	9	20	67	101	116
Diphtheria	0	0	0	1	1
Mumps	217	193	4,169	2,933	3,729
Scarlet Fever & Strep Sore Throat	2,233	1,425	18,433	9,942	13,304
Tetanus	0	0	1	1	2
Poliomyelitis (paralytic)	0	0	0	0	1
Hepatitis	372	442	3,267	3,665	4,322
Salmonellosis (other than S. typhi)	106	77	650	695	781
Typhoid Fever (S. typhi)	2	1	12	7	7
Shigellosis	67	63	515	506	574
Aseptic Meningitis	75	64	389	215	266
Encephalitis	19	12	148	84	108
Meningococcic Meningitis	3	8	44	48	55
H. Influenza Meningitis	6	7	77	66	81
Tuberculosis	101	131	1,184	1,398	1,609
Syphilis	417	467	3,633	4,094	4,815
Gonorrhea	3,670	2,704	26,112*	20,538	24,728

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, MD, Director
Michigan Department of Public Health

*corrected totals

Perinatal tips

By Paul M. Zavell, MD
Detroit

The following case from the files of the Wayne County Medical Society Perinatal Mortality Study Committee is presented as an aid in continuing education.

Maternal

This was the second pregnancy for a 23-year-old Gravida II, Para I (II) A+ white mother. Her first child is home and well, and this pregnancy of 40 weeks duration was seemingly entirely uncomplicated. She went into labor at 4:45 a.m. and proceeded quickly thereafter to the hospital. Beginning about 6:50 a.m. fetal heart tones were noted to be very irregular ranging from 100 to 200/minute and influenced little by her labor pains. Because a sterile vaginal exam revealed her to be 90 percent effaced and 6-7 cm dilated, her membranes were artificially ruptured. Labor quickly became more intense. By 7:20 a.m. she was fully effaced and 7-8 cm dilated. However the F.H.T's were even more irregular than before (40 to 200/-min). In the face of this emergency a Duhrssen's incision of the cervix was done enabling delivery of the infant by mid-forceps at 7:30 a.m. Position was rotated OLT to OLA. In the process of delivery the cord was noted to by wrapped around the neck and shoulders twice and under marked tension. This could not be corrected manually so that double clamping followed by severance of the cord was necessary. During labor the mother received 50 mgm of Demerol, 1/100 of Scopalamine, 20 mgm of Largon and I.V. Ringer's Lactate solution with added Pitocin. Anesthesia was by spinal.

Fetal

At birth this 7 pound 5 ounce white male infant was markedly cyanotic. Color returned to normal after spontaneous onset of crying. However in order to maintain pink color and relieve depressed respirations it was necessary to suction the nose and throat, aspirate the stomach contents and give facial O_2 by mask at 5 L/minute. The infant was placed in an isolette and by 10 a.m. (2½ hrs. of age) color remained pink without respiratory distress (however he still needed small amounts of O_2). At 10:30 a.m. (3 hrs. of age) the nose was suctioned (mucus questionable) and bright red fresh blood was obtained. Soon thereafter the infant vomited a small amount of fresh blood. At about this time it was also noted that at the site of the vitamin K injection (given routinely as 1.0 mgm aqua mephyton) there was fresh bleeding and a large surrounding hematoma.

By 11:00 a.m. (3½ hrs. of age) type and cross match had been drawn but constant pressure on the venipuncture site was necessary to stop bleeding. Following this venipuncture the infant became increasingly more cyanotic and respiratory rate rose rapidly to 60-80/min but heart rate remained at 120-140 minute. Hemoglobin was then 13.0 gm with prothrombin time of 300. Just before a scalp I.V. was started at 2:30 p.m. (7 hours of age) gross hematuria was noted. The infant was then given fresh A+ compatible whole blood (50cc) as a transfusion. Cyanosis and increased respiratory rate however continued so that a chest x-ray was done at about 8½ hours of age showing "a reticulated pattern with increased vascularity." This was interpreted as indicating aspiration of blood. Following the blood transfusion the infant seemed to slowly improve so that no new bleeding was noted and gradually oxygen in the isolette was discontinued by 26 hours of age. However 2 hours later rigidity of the upper back and stiff upper extremities with clenched fists occurred.

Gradually the anterior fontanelle had become full, tense and pulsating. An L.P. was done revealing grossly bloody spinal fluid that would *not* clot upon prolonged standing. Occasional tremors began to occur. A consultation with a neurosurgeon resulted in the diagnosis of "Hemorrhagic disease of the newborn with subarachnoid hemorrhage but no real evidence of focal damage of the brain." Occasional tremors continued to occur until the tenth day of life (Rx'd with oral phenobarbital). However there was no *new* evidence at any time thereafter of new bleeding.

On the fourth day of life the infant was markedly jaundiced (bilirubin total of 15 mgm%) and this was successfully treated by phototherapy. Also by the fourth day of life all fullness of the anterior fontanelle was gone but some C.N.S. rigidity remain-

(Continued)

Doctor Zavell is chairman, Perinatal Mortality Study Committee, Wayne County Medical Society, and a member of the Neo-Natal and Hospital Care Committee, American Academy of Physicians.

ed evident until the seventh day. A repeat L.P. on the eighth day of life showed 128 cells (only 10 RBC's). Mycroscopic hematuria persisted until about the eighth day of life. Of interest is that a repeat chest x-ray taken only 24 hours after the blood was given (i.e. on the second day of life) showed complete clearing of the chest. A circumcision was done uneventfully on the 14th day of life. Multiple studies were done in the hospital. Final diagnosis after help from a hematologist was hemorrhagic disease of newborn due to temporary lack of Factor V.

Perinatal Committee Comments

1. Since hemorrhage in the newborn can be caused by various factors or conditions it is still fundamental in arriving at a correct diagnosis and subsequent treatment to get a complete history (i.e., familial, maternal, birth, etc.) as well as to do a thorough physical exam (i.e. where, when and kind of bleeding) as possible.
2. Some factors that play an important part in hemorrhage in the newborn are vitamin K deficiency, inability of the liver to synthesize necessary factors for coagulation (because of immaturity, infection, etc.), thrombocytopenia and abnormalities of the basic coagulation mechanisms (usually inherited).
3. In trying to arrive quickly at a proper diagnosis two basic laboratory procedures can be done. They are (1) an apt test (Sodium Hydroxide Test) to help differentiate between fetal and maternal blood and (2) a platelet smear (preferably cover-slip smear) and/or platelet count to help rule out thrombocytopenia.
4. Hemorrhagic disease of the newborn due to vitamin K deficiency can be easily prevented by parenteral dose of 0.5 mgm (for prematures) and 1.0 mgm (for full term infants) of vitamin K, given *shortly* after birth. Remember that premature infants respond less predictably than full term infants and may need additional vitamin K or blood later.
5. If an infant is showing signs of hemorrhage and vitamin K has not been given, this should be given promptly. The recommended dose is 2 mgm of vitamin K, I.V.
6. It cannot be stressed too strongly that although a correct diagnosis is the ideal before treatment is started, *if* hemorrhage is of such proportions as to be life threatening, the infant should be promptly transfused. (However, sample of his blood for later studies can be obtained at this time before any blood is given).
7. Because hematology has become such a complicated specialty, we strongly urge prompt consultation with a hematologist if there is any question as to the diagnosis or proper treatment when hemorrhage is abundant or life threatening. This is best handled in larger hospitals with trained pediatric staffs.

Doctor Vanselow selected as Arizona dean

Neal A. Vanselow, MD, chairman of the University of Michigan department of postgraduate medicine and health professions education, has been named dean of the College of Medicine of the University of Arizona. Doctor Vanselow has served as president of the Washtenaw County Medical Society during 1973.

Announcement of the appointment was made in Tucson where Doctor Vanselow will take up his position by June 1, 1974. He succeeds Merlin K. Duval, MD, who has been named vice president for health sciences of the 27,000-student university.

Doctor Vanselow will be the second dean of the medical school in Tucson which was formed in 1967. The school, which is the only MD producing facility in the state, has established a three-year curriculum.

"Doctor Vanselow's departure for another medical school is a matter of genuine regret for all of us, but his appointment as dean is certainly understandable. Part of the mission of a medical school the size and stature of Michigan's is to train outstanding teachers and administrators who move on to become leaders in their own right at other institutions," said John A. Gronvall, MD, dean of the U-M Medical School.

Doctor Vanselow is a member of the MSMS Commission on Continuing Medical Education.

Neal A. Vanselow, MD

The Physician and the Law

Legal implications of treating drug reactions

By Charles B. Maclean, PhD
Lansing
James S. Feurig, MD
East Lansing

Treatment of drug patients, like treatment of all other patients, involves some medical and legal risks. This paper is intended to help practitioners weigh the legal risk factors involved, thus enabling them to provide optimal patient care within the standards of the profession. Considering that drug (including alcohol) related emergencies account for more than half of the annual accidental injuries and deaths in the United States, there is a high probability of being confronted by patients in trouble with drugs. Drug misuse kills over 50,000 people each year and injures over a million more.[18](p.4) Too many of these persons receive no treatment or are subjected to improper treatment.[15] (p. 154), [19] (p. 508)

The reasons for this failure are many. Medical and nursing schools and hospitals have not provided adequate education in this area. Drug misusers often avoid contact with medical professionals; physicians and nurses react in kind. Many of those involved are uncertain of their legal rights and obligations in receiving or rendering emergency treatment for drug reactions.

Citing the need for change in the physician's role in dealing with behavior problems, Paul H. Blachly, MD, noted that "We physicians in the past had an unstated jurisdictional agreement with attorneys, saying in effect, 'if you bring the problem on yourself, it's not the physician's responsibility (it may be the attorney's), but if you are the helpless victim of a malady, it is our province.' "[2] (p. 29)

Through a question and answer format the authors will attempt to clarify the role of the medical professional and that of the patient in coping with drug related problems.

What constitutes treatment of drug reactions?

The authors define treatment of drug reactions as short term care (not methadone maintenance or other continuing regimen) given a person complaining and/or exhibiting psychological or physiological drug reactions or complications while in the presence of the health care professional.

How might a drug related emergency present?

Common problems include "bad psychological trips," "flashbacks," injection related complications, toxic states, withdrawal states and generalized overdose symptoms. These states may result from occasional or habitual misuse of drugs, be they licit or illicit substances.

In an "emergency" situation involving drugs, is a physician or nurse obligated to obtain "consent" before treating?

No. The Michigan "good samaritan" statute MCLA 691.1501 provides that, regardless of whether the person has reached age of majority or not:

> *A physician or registered nurse who in good faith renders emergency care at the scene of an emergency, where a physician-patient or registered nurse-patient relationship did not exist prior to the advent of such emergency, shall not be liable for any civil damages as a result of acts or omissions by the physician or registered nurse in rendering the emergency care, except acts or omissions amounting to gross negligence or wilful and wanton misconduct.*

Holder[6] notes that the courts neither expect nor require that discussions of the pros and cons of a course of treatment be given to a patient in the

This article is based in part on questions asked at the Workshop for Emergency Treatment of Drug Reactions sponsored by the Governor's Office of Drug Abuse, Oct. 24-26, 1971. The answers have been updated in light of recent legislation.

The authors appreciate the assistance provided by the following people. The appearance of their names does not necessarily indicate their total agreement with the opinions of the authors.

Richard Bates, MD; Herman Fishman chief deputy director, Michigan Department of Licensing and Regulation; Julius Hanslovsky, attorney; Philip Hogan, Michigan State Police; John Isbister, MD, Michigan Department of Public Health; Robert Miller, Medical Protective Company; Marcia Orr, attorney; John Shrank, attorney, and Charles Weirman, Michigan State Police.

(Continued)

Doctor Feurig is director of the Olin Health Center, Michigan State University. Doctor Maclean is medical educator for the Tri-County Comprehensive Drug Treatment Program, Lansing.

case of an emergency. The courts have been consistent in their judgment that "he who is saved from dying of snakebite (or a drug related emergency) has no business complaining if unavoidable effects ensue from the life-saving treatment" *(Gravis vs Physicians' and Surgeons' Hospital,* 415 SW 2d 674, Tex, 1967; *Woods vs Brumlop,* 377 P 2d 520, NM, 1962).

If the situation involving drugs is not a "life threatening" one, must a physician or nurse obtain "consent" from a parent or guardian before treating a minor?

No. MCLA 335.231 provides that:

> *A consent to care, treatment, or service by a hospital, a public clinic, a private clinic, a physician licensed to practice medicine, or a nurse registered or licensed . . . when executed by a minor who is or professes to be dependent on or subject to abuses of drugs or narcotics, is valid and binding as if the minor had achieved his majority. The consent shall not be subject to later disaffirmance by reason of minority. A parent, guardian or custodian of a minor is* **not** (authors' emphasis) *legally responsible for any care, service or treatment rendered under this act.*
>
> *The consent of another person or persons, including but not limited to a spouse, parent, custodian or guardian, is not necessary in order to authorize such care, treatment or service to be provided to the minor.*
>
> *A treating physician* **may,** *but is* **not** (authors' emphases) *obligated to inform the spouse, parent, custodian or guardian of the minor as to treatment given or needed.*

Hogan[4](p. 9) succinctly summarizes the impact of MCLA 335.231 in stating: ". . . it allows a minor to seek treatment, allows the doctor or clinic to provide it and allows both to do each without obtaining the consent of a parent or guardian and without disclosing the fact of treatment."

Who pays for drug treatment of a minor if his parents are not notified?*

MCLA 335.231 does specify that "A parent, guardian or custodian of a minor is not legally responsible for any care, service or treatment rendered under this act." There are, however, a number of approaches a physician can attempt in seeking remuneration for treatment rendered persons under 18 years of age.

The first and most workable is based on the premise that anyone who uses any drug assumes some personal responsibility for the outcome. Once a good relationship has been established with the minor the physician can, as the courts have done, work out appropriate payment, commensurate with services rendered and the patient's ability to pay.

A second, and often successful, tactic is to encourage, but not coerce, the minor to call his parents voluntarily. Since most drug use among youth is related to parental drug use[17] or the family situation, this strategy encourages all concerned to take responsibility for their actions or inaction. The drug misuse then becomes an indication of other things gone wrong in a person's life rather than "the problem."

A third, but less satisfactory, tactic is to absorb the lost fee if the minor refuses payment and the physician feels it inappropriate to notify parents.

What are the requirements for "informed consent" in a non-emergency situation?

"Informed consent" refers to the patient's right to know what the physician or nurse proposes to do in treating his condition. The patient himself is usually the one who decides whether to allow or reject proposed treatment. The physician or nurse in a non-emergency situation has a legal and moral obligation to explain in advance those reasonably foreseeable risks and hazards of treatment.[6]

Neil L. Chayet, JD, notes in ***Emergency Medicine*** that:

> *If the patient requires psychotherapy or similar treatment, the question of whether you should proceed is perhaps best answered by asking what can be done to you if you do. Your greatest risk is that you won't be paid for your services, a risk well worth taking if a child's life might be saved by such intervention. When treatment is on an emotional level, the chances of a suit based on technical battery, . . . are nonexistent.*
>
> *. . . more difficult is the case of a youngster who needs help to deal with the emotional difficulties of a problem that has not yet developed physical manifestations. Once again, to involve the parents would accomplish little more than destruction of the fragile element of trust that brought the youngster to you in the first place.* [3](pp. 216-17)

Legal issues aside, in the case of treatment of persons experiencing untoward psychological or physiological reactions from illegal drugs, the explanation of treatment to be rendered is especially crucial. The patient in this situation may bring

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**The authors propose that Michigan enact legislation taxing all drug substances (prescription drugs, over the counter drugs, alcohol, tobacco. . .) capable of producing impairment of physiological or psychological functioning. These revenues would then go into a fund for the treatment of "uninsured drug takers" in much the same way that "uninsured motorists" are covered. Fines derived from convictions for the possession, use or sale of illegal drugs could also be used in a similar way. Thus treatment of minors and of all persons suffering adverse drug effects would be remunerated with no additional burden being placed on the physician or the non-drug using public.*

with him a high degree of paranoia about being "busted" or a fear of going "crazy." Medical surroundings with their antiseptic smells and threatening sights often exacerbate these fears and this paranoia.[8](p. 1) Reassurance by the medical professional as to his intent and the course of treatment does much to establish patient trust and it significantly reduces the possibility of later legal action due to misperception and fear.

How does the principle of "privileged communication" apply to drug cases?

MCLA 600.2157 provides that:

> *No person duly authorized to practice medicine or surgery shall be allowed to disclose any information which he may have acquired in attending any patient in his professional character, and which information was necessary to enable him to prescribe for such patient as a physician, or to do any act for him as a surgeon. . .*

The "privileged communication" statute applies to treatment, not to consultation, but the law has not adequately defined the difference and to date the difference has not been challenged in the courts. Certain information can be released to appropriate agencies without patients' or parents' consent: namely, that at a particular time and place the physician did treat the patient. However, the nature of that treatment and complaint remains "privileged." It should be noted that the obligations of "privileged communication" extend to all those who work for the physician, his nurses, secretary, or trained para-professionals and that the physician is responsible for their silence.

Are there any exceptions to "privileged communication" with respect to drug treatment?

Yes. Two major situations may occur. The first allows waiver of physician-patient privilege in cases where the patient or his survivors bring action against the physician to recover for any personal injuries or for any alleged malpractice. Where the plaintiff produces any physician as witness, the physician charged may waive "privileged communication" to defend himself (MCLA 600.2157).

The second theoretical situation deals with required reporting of drug addiction.

> *Every practicing physician in the state who shall examine any person and find such person is addicted to the use of narcotic drugs shall make a report thereof to the health officer of the county, city, township or district in which such person is a resident, or to the state health commissioner when there is no local health officer (MCLA 335.204).*

Section 3 specifies the action that *may* be taken through the public health officer and the courts. Citing this statute is unnecessary and would be misleading in view of its inapplicability and the impossibility of adherence to it. The law was enacted at a time when the only treatment facility available to the physician for referral of addicts was the United States Public Health Hospital at Lexington, Ky. The Michigan Department of Public Health reports that while this statute requires physicians to report addicts to the department, reporting procedure never has been developed. Review of their records for past years indicates that indeed no addicts have been reported by physicians and that no physician has been subjected to administrative or legal action for failing to report addicts known to him.[7] Readers should be aware that addicts have been known to seek out physicians from whom they can "con" the drugs they need. Elderly physicians are particularly susceptible to this kind of manipulation. The addict grapevine quickly identifies those physicians known to be easy "marks." Blackmail by addicts of physicians on the basis of illegal prescribing habits is not uncommon.

Is there any legal requirement that physicians or hospital personnel must report to police agencies that a person admitted to their facilities is under the influence of, or is addicted to narcotics or other drugs?

No. There was a provision of MCLA 335.67 which provided that information communicated in an effort to unlawfully procure a narcotic drug or unlawfully procure the administration of any narcotic drug, shall not be deemed a privileged communication. This statute has been repealed in the Controlled Substances Act of 1971. With regard to the original question, John A. Shrank, Lansing attorney, has noted:

> *It is my legal opinion that any physician or hospital who notifies any police agency that a patient is under the influence of or addicted to drugs or narcotics is violating the doctor-patient privilege and would be civilly liable for any such communicaiton unless the patient had given a valid waiver for such communicaiton.*[16]

Have malpractice insurers had any experience with civil or criminal suits brought against physicians for treating drug users?

No. At the authors' request five major companies offering professional liability insurance conducted an exhaustive research of their experience. None of these companies could report a single instance where a claim reached its attention. The Medical Protective Company, a major insurer of Michigan physicians, reported:

> *A search of our records fails to reveal any claims handled by Medical Protective in which treatment of minor drug users was an issue, either as a lack of informed or adequate*

(Continued)

> *consent or as a failure to adhere to standard practice.*
>
> *We turned next to our Law Library to look for reported court dicisions on these issues of interest to you. Again, we were unable to locate a single case in point.*
>
> *. . . If doctors fear to treat the (drug) patients because of fear of malpractice claims, their fear is based not upon claims which have occurred in treating drug related problems.*[11]

Medical Protective does caution however, that "Our traffic seems to be more related to the type of claim in which the doctor is charged with having induced drug dependency during the course of treating some ailment."[11]

When parents demand that a minor receive treatment for drug misuse but the minor refuses, what is the physician's role?

Without a patient there is no treatment. With a reluctant patient the physician can offer his services and perspective but certainly it would be futile and counterproductive to attempt to force a change in the patient's values or life style. Such parent-child conflict is indicative of mistrust deeper than the drug situation. At best the physician can make his services available to the minor for him to accept or reject. Until the drug user feels a need to change or to seek help, intervention is difficult if not impossible.

What can be done to encourage persons with drug emergencies to seek treatment without fear of being reported to the police?

San Diego County has removed the threat and fear of arrest for persons seeking voluntary treatment of drug reactions. After their "no-bust" or "no-arrest" policy had been in effect for only five months, deaths due to drug overdose dramatically declined and the number of hospital admissions for drug problems increased significantly.[12] The authors urge Michigan medical professionals, law enforcement officers, hospital administrators, drug crisis center staff and prosecutors to jointly formulate a similar policy. At a minimum it should include an informal working agreement that treatment centers will not be harrassed or kept under surveillance in search of drug users. The resultant "Michigan No-Bust Policy" and the provisions of existing laws regarding treatment of drug users should be widely disseminated.

Conclusion

If persons in trouble with drugs are to receive the help they desperately need, the medical profession must continue to practice discretion in notifying parents. Contemporary case and claim evidence indicates that physicians have been free from prosecution with regard to treatment of drug patients. Physician concern over liability has been grossly exaggerated resulting in an "availability of treatment deficit" for persons suffering from drug misuse.

To enable physicians and nurses to conform to the community and national "standard of care" with regard to treatment of drug reactions, both medical and nursing schools must expand their teaching of diagnosis and treatment in this area. Continuing medical education in the area must be provided practitioners to better prepare them to face the results of massive drug misuse in our society.

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Advances in rehabilitative care lag behind progress in managing episodic disease

By Lionel L. Davis, MD
Tryon, N.C.

The delivery of medical care in recent years has been accompanied by many improvements in diagnosis, treatment and understanding of episodic disease and injury. It must be admitted, however, that this has not been true in the field of long term rehabilitative care. The concept of rehabilitation as an active part in the care of all disease and injury at the present time is not really accepted or consistently used as part of the health delivery profile.

Prior to the development of the polio vaccine and its successful use, most of the physio-therapy and occupational facilities were devoted to the sequelae of polio and to orthopedic related problems. The poor handling of stroke cases did not come to the attention of the medical profession until the federally financed heart, cancer and stroke programs were developed. Effectiveness has varied so greatly from state to state as to make its total impact most unsatisfactory.

Long term illness can be classified under the following headings:

1. Cerebro-vascular accidents
2. Peripheral-vascular disease
3. Arthritis in various combinations
4. Post traumatic sequelae
5. Neurological disease
6. Heart-kidney disease
7. Post surgical
8. Miscellaneous, such as bone disease, emphysema, diabetes, hepatic disease and others
9. Terminal cases

Most of the cases listed should have available good rehabilitative consultation and management. The handling of these cases presents a problem, especially in the use of general hospital beds. The movement of these patients is pressured for by all parties, and their proper disposition is very often nonexistent. There are few choices available for adequate handling of long term rehabilitative problems.

Originally the term, Extended Care Facility, was meant to provide an answer to these needs for patients over 65. This idea simply never got off the ground because Congress had passed a benefit for a nonexistent facility. In the January, 1967, issue of *Hospital Topics,* Senator Frank Moss expressed the fear that the real meaning of Extended Care would be lost in the mad rush to deliver a Nursing Home benefit. The application of the rules and guidelines developed by HEW to skilled nursing home benefits, as well as extended care benefits, has resulted in difficulties for all. Initially there was some increase in the average hospital stay. In the last few years there has been a decline, probably due to the increased pressures for discharge.

In order to admit the need for developing a plan and guidelines for a long term rehabilitative care unit one must concede that certain deficits exist in the present system.

The first point to be made is that in any general hospital there are a number of patients whose condition would make them eligible for transfer for long term rehabilitative care. This fact is easily determined by audit and classification. My personal experience has shown that from 35 - 50 per cent of the daily hospital census will fall into the over 65 age group. I have noted similar figures from various sources. It is not unrealistic to conclude that about 50 per cent of these patients would be suitable for transfer, many times at an early point of their stay.

The second point is the status of rehabilitative direction in the average general hospital. Most general hospitals have a physical-therapy department, or access to one. It is also a fact that many do not have such services available. There is seldom direction or consultation by a certified physiatrist. I know from personal communication that they are frequently not fully used where they are available. There are said to be about 1,000 physiatrists in the United States, of which there are, roughly, about 35 in Michigan. It seems obvious that in order to improve rehabilitative management in general care there needs to be an increase in the number of physiatrists. There also needs to be an increased understanding by the physician of the need and use for physiatric consultation and help. With proper usage many unnecessary procedures could be avoided and the course of care held to more productive guidelines.

The average physician has had little instruction in the disciplines of physical medicine and this condition shows little likelihood of change. When the average physician gives an order in physical medicine it is not a knowledgeable order. It follows

(Continued)

The author, a physician and surgeon in Mount Pleasant for almost 40 years, is a past president of the Gratiot-Isabella-Clare County Medical Society. He is past chairman of the MSMS Rehabilitation Committee.

that the person receiving the order is usually expected to prescribe the patient's management. It is questionable whether he has the legal right to do so. He is not professionally trained in the medical aspects of disease and should not wish to assume this responsibility. This points out a considerable "gray" area.

As another point, I do not believe that the average general hospital has the trained personnel, environmental milieu aura or the rehabilitative philosophy in its management and perspective to give more than token emphasis to rehabilitative programming. Good rehabilitation requires a consistent, positive approach both in the thought and actions of personnel. There actually are deficits too numerous and too obvious to mention.

I have tried to point out why I believe that a new coordinated approach is needed in planning for long term rehabilitative care. I shall try to develop to some extent how I believe answers to this problem can be reached.

The first part of the answer lies in the medical profession itself. Except for an occasional fragmented effort the problems of long term rehabilitative care have been shunted aside. The medical graduate has had very little contact with the discipline of physical medicine. For instance, the history of stroke management has been a sorry chapter in medical management. In recent years there has been some improvement, but to assume that at the present time it is generally satisfactory would be a case of considerable delusion. I believe that the chairman of any department of physical medicine would readily agree that the training of medical students should give much greater emphasis to the philosophy and methods of rehabilitation.

The second part concerns itself with the major emphasis of this article. In order to create the best conditions for rehabilitation as a part of a smooth, integrated treatment pattern it will be necessary to develop the long term rehabilitation facility. This should be a specialized unit with the following basic requirements:

1. *It should be either an adjunctive part of a hospital or have close connections to one or more.*
2. *There must be a continuity of professional staff in patient management. The staff must be subject to the usual rules, regulations and guidelines.*
3. *It must be a major unit providing a course of positive action and environment. This is in contrast to the laissez-faire attitude existing in some nursing homes.*
4. *It must have available ancillary services on a par with a general hospital.*
5. *The paramedical staff must be trained in all rehabilitative techniques and philosophy.*
6. *Conference systems for evaluation of patient treatment, progress and disposition should be used where indicated, utilizing paramedical as well as medical personnel.*
7. *Physiatric consultation should be required. Consultation in all necessary fields should be available.*
8. *The facility should be constructed and organized in such a way that*
   - a. *an outpatient service can be developed,*
   - b. *a day care center can be established,*
   - c. *home nursing can be correlated,*
   - d. *home services can be directed and*
   - e. *transportation can be provided.*

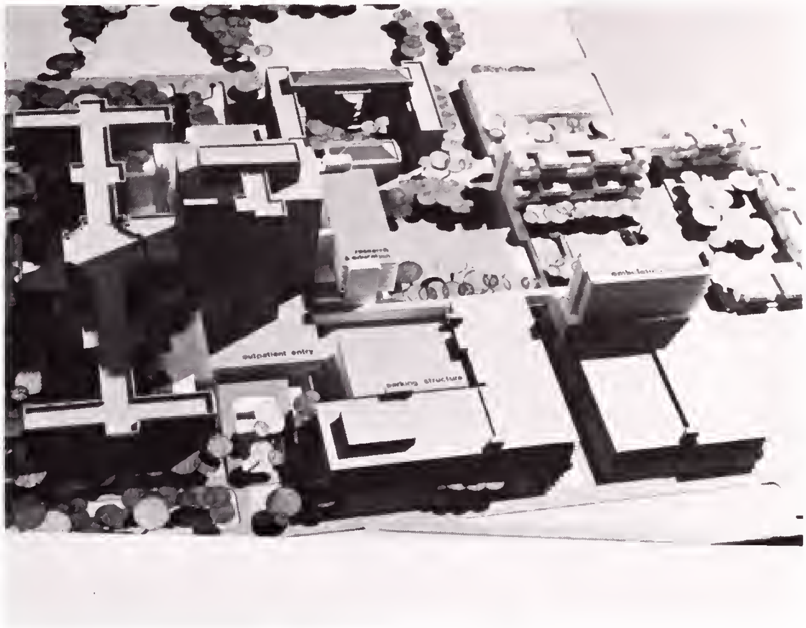
   This point infers that every possible aid should be available to maintain the maximum in home management potential.
9. *Psychiatric help may be necessary in all phases.*

An effort to establish guidelines for a long term care is complex. Doctor Edward Harmon, until recently a consultant with the Bureau of Health Facilities of the Michigan Department of Public Health, has completed such a project, as chairman of a special committee consisting of representatives from the associations and societies normally involved, as well as from the departments of rehabilitation of Wayne State University and the University of Michigan. This constitutes a well developed trial program and can be an excellent beginning pattern for further long term, long range planning.

In conclusion, to continue to ignore the need for consistent, adequate care for the long term chronically ill and disabled is a disservice to the dignity and physical potentials of these people. The medical profession should not be apathetic to such needs. It should not point to various fragmentary efforts as solutions to the lack of viable objectives. It should not be satisfied with the welfarizing, dignity destroying storage bin disposition which becomes the end cycle of so many lives.

In view of the emphasis now being given to catastrophic illness insurance on a national level, it seems urgent that measures along this line be developed. Catastrophic illness is certainly just another phrase meaning long term illness and disability. It is obvious that studies for auditing need and the direction of care profiling should be carried on.

Ford Hospital announces expansion plan



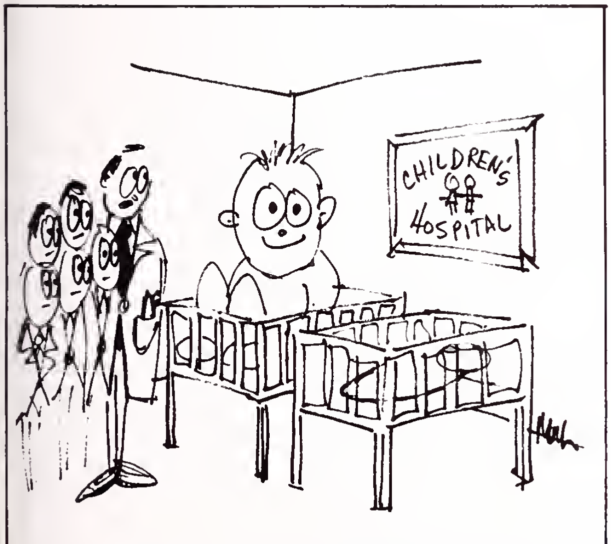
Architectural model shows how Henry Ford Hospital in Detroit will be expanded during a 10-year development plan. The I-shaped building at left and the high structure just to its right are the present hospital and clinic buildings. To be added will be a 10 million dollar education and research building (center), housing for intern and resident physicians (right), housing for ambulatory patients from out of town (a high structure at the right), and additional parking (top). Plans also call for the remodeling of patient areas and student nurses' housing, construction of new emergency facilities and a service building.

Henry Ford Hospital has announced a 300 million dollar ten-year development program based on the intent of the trustees of the Ford Foundation to make grants to the hospital over a ten-year period that would produce 100 million dollars. To help launch the hospital's program, the foundation has provided initial support of 25 million dollars.

The multi-faceted program includes major expansion of the hospital's services to medical education, research and community health care, as well as improvements to the institution's facilities.

The Ford Foundation program of support to the hospital was announced jointly by Benson Ford, president of the board of trustees of Henry Ford Hospital, and McGeorge Bundy, president of the Ford Foundation.

Ford said that to parallel the foundation's support the hospital will seek an additional 200 million dollars from other sources during the next decade.



First we got an Endocrinology consultation, then we called a college football scout.

New mobile unit aids kidney failure victims

Little Traverse Hospital, Petoskey, with financial assistance from the Kidney Foundation of Michigan and the Michigan Department of Public Health, has put into service the state's first traveling artificial kidney center. The vehicle will visit communities where hemodialysis treatments are not available to provide patient services. Most victims of kidney failure who live in northern Michigan and the Upper Peninsula have been traveling to Petoskey three times weekly, in some cases going several hundred miles for treatments. These patients still must make one trip weekly to the hospital, but can be treated closer to home twice a week. The unit's initial schedule takes it to Sault Ste. Marie, Grayling and Traverse City. A converted motor home is used in the project, which has had an initial cost of $45,000.

Socio-economic

Fee survey shows average increase of less than 6 per cent since 1971

By John Anthony, Chief
MSMS Bureau
of Economic Information

The MSMS Bureau of Economic Information has found that physicians' fees have risen only 5.98 per cent since July, 1971, when it conducted its first fee survey.

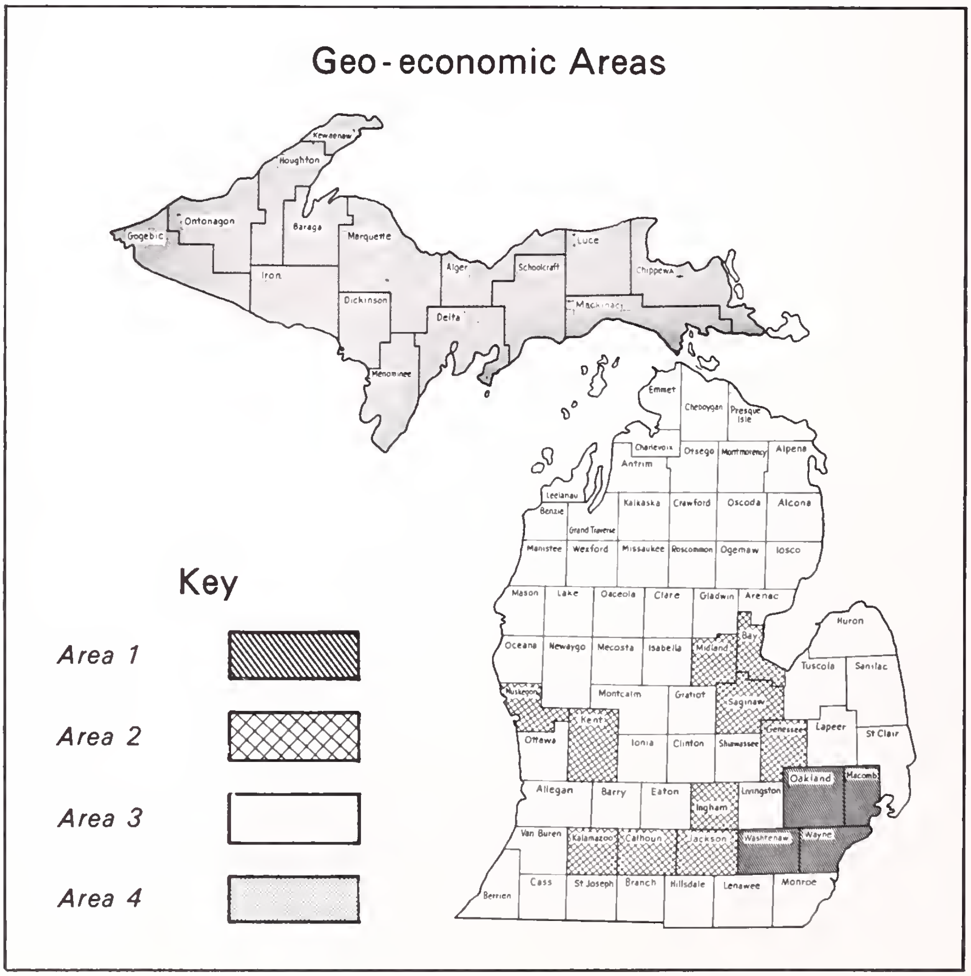
The 1973 Physician Fee Survey, which was run this summer by the MSMS bureau, resulted in over 3,000 responses, or 43 per cent of the total number of surveys mailed to 22 different specialty groups.

During the same time that Michigan doctors' charges rose 5.98 per cent, the Consumer Price Index of all commodities rose 8.9 per cent, and the service component of the CPI rose 7.8 per cent.

There was noted a great difference in fees charged by specialists versus generalists. For example, the in-hospital first day average charge of an internist was 48 per cent higher than that of a general practitioner, and a followup or return office visit was 29 per cent higher than the fee of the GP. Another example is the average amount charged for a tonsillectomy is 17 per cent more for an otolaryngologist than for a GP.

The results of this survey and others conducted by the bureau are now a part of its growing statistical data bank. The actual mean fee for a specific procedure or precedures can be obtained by requesting the data from the Bureau of Economic Information at MSMS headquarters.

The procedures below are just a few of the hun-


Geo-economic Areas
Keweenaw
Houghton
Ontonagon
Gogebic
Baraga
Marquette
Iron
Luce
Alger
Schoolcraft
Chippewa
Dickinson
Mackinac
Delta
Menominee
Emmet
Cheboygan
Presque Isle
Charlevoix
Antrim
Otsego
Montmorency
Alpena
Leelanau
Benzie
Grand Traverse
Kalkaska
Crawford
Oscoda
Alcona
Manistee
Wexford
Missaukee
Roscommon
Ogemaw
Iosco
Mason
Lake
Osceola
Clare
Gladwin
Arenac
Huron
Bay
Oceana
Newaygo
Mecosta
Isabella
Midland
Tuscola
Sanilac
Muskegon
Montcalm
Gratiot
Saginaw
Kent
Ottawa
Ionia
Clinton
Shiawassee
Genessee
Lapeer
St Clair
Oakland
Macomb
Allegan
Barry
Eaton
Ingham
Livingston
Van Buren
Kalamazoo
Calhoun
Jackson
Washtenaw
Wayne
Berrien
Cass
St Joseph
Branch
Hillsdale
Lenawee
Monroe
Key
Area 1
Area 2
Area 3
Area 4

dreds of fees the Bureau now has information about. They demonstrate the wide variance of physician's charges that now exist. The data below should be interpreted in the following manner:

If the state mean fee (X) for a tonsillectomy (code 3107J) is $115, then the Area 1 mean fee is 1.08 multiplied by $115, or $124. Area 2's mean fee is $116, Area 3's mean fee is $106, and Area 4's mean fee is $89.

One more example may make it even clearer:

Let's assume the mean fee (X) for an appendectomy is $231. Then Area 1's mean fee is 1.08 multiplied by $231, or $249, and Area 4's mean fee is .89 multiplied by $231, or $206.

Michigan State Medical Society
Physician Fee Survey

Code No.	Description	State Median Fee	State Mean Fee	Area 1 Mean Fee	Area 2 Mean Fee	Area 3 Mean Fee	Area 4 Mean Fee
1242G	Arthrocentesis, aspiration or injection, major joint (e.g. shoulder, hip, knee joint, etc.)	.96X	X	1.08X	1.08X	.69X	.73X
2180H	Bronchoscopy, diagnostic	.84X	X	1.01X	.99X	.95X	NA
3107J	Tonsillectomy, with or without adenoidectomy, under age 12	1.00X	X	1.08X	1.01X	.92X	.77X
3350F	Appendectomy	.97X	X	1.08X	.94X	.92X	.89X
3400I	Sigmoidoscopy, diagnostic, initial	.83X	X	1.11X	.94X	.94X	1.11X
3476I	Hemorrhoidectomy, internal and external	.95X	X	1.11X	.90X	.90X	.85X
3620B	Cholecystectomy	.98X	X	1.08X	.94X	.93X	.89X
3740H	Inguinal hernia, unilateral	.93X	X	1.09X	.93X	.92X	.88X
4073C	Transurethral resection of prostate, including control of postoperative bleeding during hospitalization, complete (electroresection)	1.02X	X	1.05X	.93X	1.00X	.86X
4681C	Dilation and curettage, diagnostic and/or therapeutic (non-obstetrical)	.88X	X	1.12X	.86X	.87X	.90X
4685D	Total hysterectomy (corpus and cervix) with or without tubes and/or ovaries, and/or dilation and curettage	1.01X	X	1.09X	.91X	.88X	.86X
4842A	Vaginal delivery only (with or without forceps and/or episiotomy	.83X	X	1.07X	.93X	.91X	.79X
5570G	Extraction of lens (intracapsular or extracapsular), with or without iridectomy, unilateral	.97X	X	1.08X	.92X	.96X	1.00X
5935B	Stapedectomy with insertion of prosthetic stapes with fenestration of the oval window	.98X	X	1.01X	.99X	.98X	NA
7102G	Chest, two views or stereo	1.00X	X	1.07X	.93X	1.00X	1.00X
7337I	Upper gastrointestinal tract, with or without delayed films	1.08X	X	1.11X	92X	1.00X	.73X
9370H	Electrocardiogram, with interpretation and report	.88X	X	1.00X	1.00X	.88X	.88X
	Initial office visit with history and physical)general Practice)	.84X	X	1.11X	1.11X	.84X	.84X
	Initial visit with limited workup (General Practice)	.91X	X	1.18X	.91X	.82X	.73X
	Followup or return visit (General Practice)	1.00X	X	1.29X	1.14X	.86X	.86X

Small doses

Ralph V. August, MD, of Muskegon Heights,

received a distinguished service award from the American Society of Clinical Hypnosis at its annual meeting in October in Toronto. He was honored for outstanding work in the use of medical hypnosis and received particular recognition for his color, sound film, "Hypnosis as the Sole Anesthesia for Caesarean Section," produced by the Upjohn Company of Kalamazoo.

G. Jan Beekhuis, MD, of Detroit,

was a guest faculty member for a course on "Functional Cosmetic Surgery of the Nose" in mid-October at McGill University in Montreal. Doctor Beekhuis is an otolaryngologist on the Providence Hospital staff and a Wayne State University School of Medicine faculty member.

Daniel D. Chapman, MD, of Ann Arbor,

has been named an assistant director for clinical therapeutics in the clinical investigation department of the Parke, Davis & Company Research Laboratories in Ann Arbor.

Robert K. Curry, MD, of Homer,

who has announced his plans to retire after 40 years of medical practice in the Calhoun County community, was honored with a series of civic tributes Oct. 5. To recognize Doctor Curry's contributions to the Homer High School athletic program, the school will rename its football field in his honor.

Jay C. Day, MD, of Detroit,

received the Bruce H. Douglas Award for outstanding contributions to tuberculosis treatment and control from the Michigan Thoracic Society at the combined annual meeting of the society and the Michigan Tuberculosis and Respiratory Disease Association Oct. 18 at Michigan State University. Doctor Day is on the faculty of the WSU School of Medicine.

James M. Davis, MD, of South Haven,

has been appointed director of the Van Buren County Health Department.

Irving Feller, MD, of Ann Arbor,

has been chosen to direct the 1974 Southeastern Michigan Science Fair for junior and senior high school students to be held April 26 and 27, 1974, at the University of Michigan. Doctor Feller is clinical professor of surgery at the U-M Medical School and director of the University Hospital Burn Unit.

John Freud, MD, of Monroe,

was honored at a dinner Oct. 17 by the Family Centered Education Association of Monroe for his achievements in the field of family centered maternity care. He was given a plaque at a dinner held in his honor in Monroe.

David Kahn, MD, of Lansing,

has been appointed professor and director of dermatological programs for the College of Human Medicine at Michigan State University. Doctor Kahn has undertaken his duties at the university on a part-time basis while continuing his private practice in dermatology.

Henry D. Kaine, MD, of Southfield,

has been reelected president of the Michigan Diabetes Association. James J. Aiuto, MD, of St. Clair Shores, was elected vice president. Newly elected members of the board of directors include Thomas Billingslea, MD, and William E. Rush, MD, both of Detroit, and William B. Weil, MD, of East Lansing.

Albert C. Kerlikowske, MD, of Marine City, and Henry K. Ransom, MD, of Ann Arbor,

received distinguished alumni awards from the University of Michigan Medical Center at the 1973 alumni reunion held Oct. 19 at Towsley Center in Ann Arbor. Doctor Kerlikowske was director of University Hospital in Ann Arbor for 25 years prior to his retirement in 1969. Doctor Ransom is professor emeritus of the U-M department of surgery. Both physicians were graduated from the U-M Medical School in 1923.

H. Frazyer Mattson, MD, of Hillsdale,

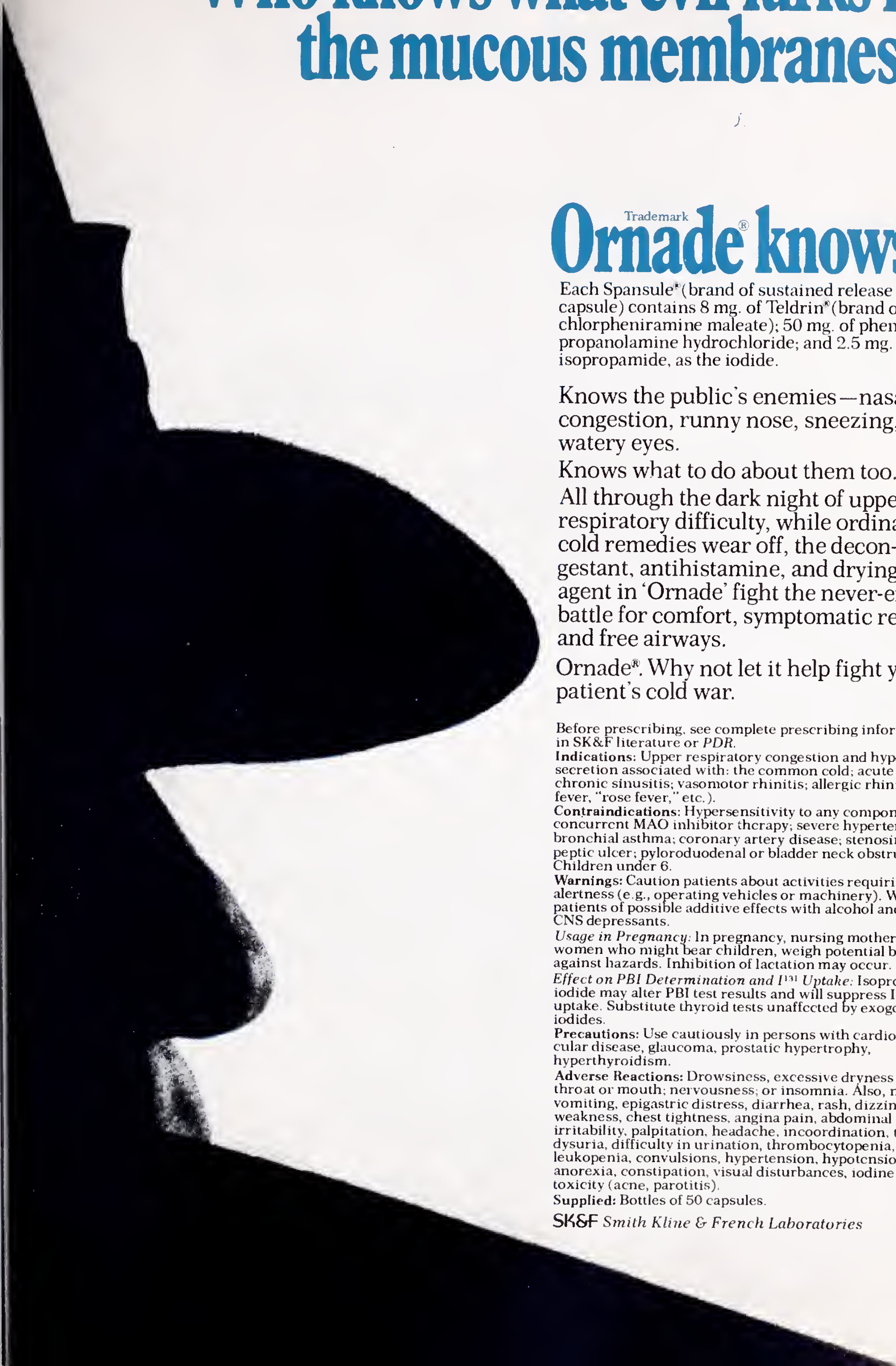
a retired surgeon, was honored Oct. 5 when he received an Alumni Achievement Award from Hillsdale College, where he was graduated in 1925, before beginning medical studies at the University of Michigan. Doctor Mattson was Hillsdale College physician for several years and is a past president of the Hillsdale County Medical Society.

Hermann K.B. Pinkus, MD, of Monroe,

professor of dermatology at the Wayne State University School of Medicine, will direct research under a $52,958 United States Public Health Service grant to seek improved methods of prevention and treatment of environmental

(Continued on page 866)

Who knows what evil lurks in the mucous membranes?



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Warnings: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Warn patients of possible additive effects with alcohol and other CNS depressants.
Usage in Pregnancy: In pregnancy, nursing mothers and women who might bear children, weigh potential benefits against hazards. Inhibition of lactation may occur.
Effect on PBI Determination and I^{131} Uptake: Isopropamide iodide may alter PBI test results and will suppress I^{131} uptake. Substitute thyroid tests unaffected by exogenous iodides.
Precautions: Use cautiously in persons with cardiovascular disease, glaucoma, prostatic hypertrophy, hyperthyroidism.
Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth; nervousness; or insomnia. Also, nausea, vomiting, epigastric distress, diarrhea, rash, dizziness, weakness, chest tightness, angina pain, abdominal pain, irritability, palpitation, headache, incoordination, tremor, dysuria, difficulty in urination, thrombocytopenia, leukopenia, convulsions, hypertension, hypotension, anorexia, constipation, visual disturbances, iodine toxicity (acne, parotitis).
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rimarily on animal studies.

Note: Oral contraceptives are complex medications. As with all medications they should be prescribed with discriminating care, and only after reference to full prescribing information. For brief summary of prescribing information, please see next page

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Each white tablet contains: ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg.

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Actions—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in the United States. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor such as epilepsy, migraine, asthma, cardiac or renal dysfunction require careful observation. In breakthrough bleeding, and in al cases of irregular bleeding per vaginam, nonfunctional cause should be borne in mind. In undiagnosed bleeding per vagina adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and th drug discontinued if the depression recurs to a serious degree. An possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits furthe study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patient should be carefully observed while receiving Ovulen or Demule therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask th onset of the climacteric. The pathologist should be advised o Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrate between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, suc a relationship has been neither confirmed nor refuted for the fo lowing serious adverse reactions: neuro-ocular lesions, e.g., retina thrombosis and optic neuritis.

The following adverse reactions are known to occur in patient receiving oral contraceptives: nausea, vomiting, gastrointestina symptoms (such as abdominal cramps and bloating), breakthroug bleeding, spotting, change in menstrual flow, amenorrhea durin and after treatment, edema, chloasma or melasma, breast change (tenderness, enlargement and secretion), change in weight (i crease or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported i users of oral contraceptives, an association has been neither co firmed nor refuted: anovulation post treatment, premenstrual-lik syndrome, changes in libido, changes in appetite, cystitis-like sy drome, headache, nervousness, dizziness, fatigue, backache, hi sutism, loss of scalp hair, erythema multiforme, erythema nodosum hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of ora contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin Factors VII, VIII, IX and X; thyroid function: increase in PBI an butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Prac *13*:267-279 (May) 1967. **2.** Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebra Thrombosis and Embolism in Women of Child-Bearing Age, Bri Med. J. 2:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R Investigation of Relation Between Use of Oral Contraceptives an Thromboembolic Disease. A Further Report, Brit. Med. J. 2:651-65 (June 14) 1969. **4.** Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Green G. R., and Smith, H. E.: Thromboembolism and Oral Contrace tives: An Epidemiologic Case-Control Study, Amer. J. Epide *90*:365-380 (Nov.) 1969.

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Each tablet contains: norethynodrel 2.5 mg./mestranol 0.1 mg.

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Indication—Enovid-E is indicated for oral contraception.

The *Special Note*, *Contraindications*, *Warnings*, *Precautions* ar *Adverse Reactions* listed above for Ovulen and Demulen are app cable to Enovid-E and should be observed when prescribing Enovid-

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brand of norethynodrel with mestranol

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MATERNAL HEALTH DESK REFERENCE CARD NO. 16

(Sponsored and Prepared by the Committee on Maternal and Perinatal Health,
Michigan State Medical Society)

AMNIOCENTESIS (Part I)

Amniocentesis is now established as one of the most important and versatile tools for antenatal diagnosis. In trained hands it is reasonably safe if proper indications and safeguards are respected:

Basic Requirements for Amniocentesis

1. Performance of the procedure by an experienced individual.
2. Reliable facilities for the performance of the desired tests, including tissue culture if indicated.
3. Ability to provide treatment, or referral, indicated by the test results, including counseling.

Technique

Refer to Mental Health Desk Reference Card #9. This technique is applicable to late pregnancy.

Amniocentesis done in early pregnancy must be modified as to needle size, puncture site, etc., and is best done by experienced personnel. Collection of fluid for genetic culture and study may have technical preservation and transportation problems, which should be cleared with the laboratories doing the studies before the procedure is done.

Risks

a. Maternal
1. Bleeding, infection, blood group sensitization, bowel perforations and other trauma.

b. Fetal
1. Abortion, puncture trauma and possible (theoretical) induced malformation.

Complications will be minimized by adherence to the following safeguards:

1. Strict aseptic technique
2. Transabdominal rather than transvaginal approach
3. Very strict selection of cases particularly for early amniocentesis.
4. Preliminary placental localization by ultrasound or isotopes, (Cr-tagged red cells), Radioiodinated Serum Albumin, etc.
5. Use antibody titers before and after procedure in RH negative patients. The possible use of Rhogam is under evaluation at present.

INDICATIONS

Technology is constantly extending the use of this procedure. The principal uses at present, however, are:

I. Assessment of fetal maturity

II. Prenatal detection of genetic disorders:
  A. Direct diagnosis of chromosomal aberrations or specific metabolic disorders
  B. Sex determination in sex-linked disorders
  C. Metabolic disorders

III. Diagnosis and follow-up of iso-immune patients

IV. Instillation of contrast material for placental localization and fetal death confirmation, etc.

V. Induction of abortion or labor with therapeutic agents

I ASSESSMENT OF FETAL MATURITY

A. *Creatinine*—2 mgm % plus level in amniotic fluid in normal pregnancies usually indicates a fetus of more than 37 weeks gestational age. A level of 1.7 MGM/100 ML amniotic fluid equates to an infant of 35 weeks gestation or more unless the maternal serum level is elevated. A direct relationship between amniotic and maternal serum levels of creatinine is maintained with a ratio of 3:1 found even in the presence of maternal hypertension.

1. Conditions Associated with Low Values.
   - a. Prematurity—if early delivery date is required determine L/S ratio (below)
   - b. Possible renal anomalies
   - c. Rh sensitization—decrease occurs after 37 weeks
   - d. Laboratory or technique errors
2. Conditions Associated with High Values.
   - a. Diabetes mellitus—false high positive values may occur
   - b. Toxemia and hypertensive diseases—false high positive values may occur
   - c. Post-datism
   - d. Labor
   - e. Laboratory or technique error
3. Interpretation and Use of Values.
   - a. Repeat C-Sections—2.0 mgm % needed to assure maturity. 1.8 mgm % may occasionally be adequate if date "certain"
   - b. Elective Inductions—2 mgm % + needed to assure maturity
   - c. Suspected Post-datism—2.5 mgm % or higher may be found

d. False "negative" (low) are not rare. A value of 1.4 may be a low normal for a 37 gestation. Any patient with questionable findings should have an L/S ratio determined and correlated.

B. *Lecithin Sphingomyelin (L/S ratio)*

As the fetal lung matures some of the pulmonary secretions containing phospholipid components of the pulmonary surfactant system find their way into the amniotic fluid. The absolute concentration of these components is variable but the ratio of lecithin to sphingomyelin is proportional to the risk of the baby developing a respiratory distress syndrome. The failure to expand being the Respiratory Distress Syndrome (R.D.S.).

1. Conditions Associated with Low Values.
   a. Immature fetal lungs
   b. Poor communication from lungs to amniotic fluid (congenital obstruction)
   c. Laboratory or technique errors
2. Conditions Associated with High Values.
   a. Mature fetal lungs (Ratio up to 4:1 common)
   b. Diabetes and Toxemia—although the reason for this elevation has not been established, there is no evidence at this time that this falsely indicates mature fetal lungs
   c. Laboratory or technique errors
3. Interpretation and Use of Values (L/S ratio).

2.0 or greater	Mature	No RDS on delicery expected
1.5 or less	Immature	RDS common occurrence
.5-1.9	Transitional	Mod. to mild RDS possible. Lung maturation achieved nearly always within 14 days of sampling. Repeat tap in 1 week.
.0-1.49	Immature	Mod. to severe RDS possible. Lung maturation achieved a variable time from amniocentesis, usually in 10-21 days. Repeat tap in 2 weeks.
Less than 1.0	Markedly Immature	Severe RDS probable. Lung maturation may require many weeks. Retap no sooner than every 2 weeks.

C. *Bilirubin*

On spectopholometric scan the Δ OD gradually decreases as pregnancy progresses, dropping to less than 0.05 or disappearing after 36 weeks. Less than 0.02 usually indicates maturity in the absence of erythroblastosis fetalis. Low false values in prematures occasionally occur in Negroes and high false occasionally in white patients.

D. *Fetal Fat Cells (FFC)*

With increasing maturity, increasing percentages of cells containing lipid substances and staining orange with fresh, cold 10% Nile Blue stain are found in the amniotic fluid. This is probably related to increasing functional maturity of fetal sebaceous glands.

% Orange Staining Cells	**Weeks Gestation**
Less 1%	Less 34 wk.
1-10%	34-38 wk.
10-50%	38-40 wk.

The above figures are relative, not absolute. For practical use if 25-50% fetal fat cells are found using this stain the pregnancy can be considered reasonably mature.

Creatinine 1.5 mgm + 2 mgm + 20% = 100% maturity
FFC 10% = 90% maturity

Over 50% FFC almost always relates to a fetus over 2500 grams and 36 weeks or older.

The above tests and values have been established as having reliable clinical value in the assessment of fetal maturity. No one test or value should be relied upon. All must be correlated with clinical evaluation, judgement and other procedures such as:

1. Ultrasound measurement of Biparietal diameter or fetal skull area.
2. X-Ray for appropriate epiphyseal centers including distal femoral epiphyses and proximal tibial epiphyses of the fetus.

MATERNAL HEALTH DESK REFERENCE CARD NO. 16

(Sponsored and Prepared by the Committee on Maternal and Perinatal Health,
Michigan State Medical Society)

AMNIOCENTESIS (Part II)

II. PRENATAL DETECTION OF GENETIC DISORDERS

Both amniotic fluid and cells are utilized for prenatal diagnosis. Metabolites from fetal urinary excretion may establish a diagnosis in some diseases. Amniotic fluid cells are derived mainly from fetal skin, amnion, respiratory tract, umbilical cord and genito-urinary tract. They are predominently fibroblastic with some epithelioid and mixed cells found.

Cultured cells are needed in most cases since cells from direct aspiration are desquamated and dying, affecting analysis. Successful and reliable analysis on a single specimen often is achieved. The science has not reached a level where in all cases it can be used as a routine method of diagnosis. One major source of error is the presence of twins being undetected.

General Requirements

It is desirable where possible to have preconceptual consultation in those families where genetic problems have been previously noted.

Because of abortion law requirements, the amniotic fluid is best obtained at 14-16 weeks, allowing 4-6 weeks for culture diagnosis.

Indications for Amniocentesis (for genetic diagnosis)

Because the procedure is not without maternal or fetal risks the following are practical but not mandatory.

1. Advanced maternal age (usually 40 years or over)
2. Previous child with Downs Syndrome or chromosome disorder
3. A parent who is a chromosome translocation carrier
4. A previous child with a severe sex-linked recessively inherited disease or a sister of a child with the disorder (i.e., Duchenne's dystrophy, etc.).
5. A significant chance of having one of the biochemical diseases listed below as amenable to antenatal diagnosis

A. *Chromosomal Aberrations*

The frequency of chromosomal aberrations is about 5 per 1000 births in general and 1% if stillbirths are included.

Risk of Down's Syndrome

Age of Mother	Incidence
29	1:3000
30-34	1:600
35-39	1:280
40-44	1:70
45-49	1:40
All	1:665

Chromosomal Aberrations Detectable By Amniotic Fluid Cell Culture and Karyotype

Down's Syndrome
    Trisomy 21
    Translocation D/G
Turner's Syndrome XO
Klinefelter's Syndrome XXY
Trisomy 18 (E group) Edward's Syndrome
Trisomy 13-15 (D group) Patau's Syndrome
Cri du chat Syndrome (Bp.)
XXX females
XYY males

B. *Sex Linked Disorders.*

Accurate fetal sex diagnosis is possible in maternal carriers of sex linked disorders. This can usually be done by sex chromatin analysis of uncultured amniotic cells, normal females having a sex chromatin body which is absent in males. A routine cell culture to allow determination of a full Karyotype should be done since a fetus with Turner's Syndrome (45, XO) or Klinefelter's (47, XXY) would be assigned the wrong sex.

X-Linked Disorders For Which Diagnostic Amniocentesis May Be Helpful

Hemophilia
Duchenne's muscular dystrophy
Nephrogenic diabetes insipidus
Hunter's syndrome
Lesch-Nyhan syndrome
Renpenning's syndrome
Ocular albinism

In a few X-linked syndromes, a distinction can be made between affected and non-affected male fetuses. In others only the sex can be determined and a 50% risk given for males.

C. *Metabolic Disorders.*

It must be remembered that problems are still inherent in the theory and practice of specific biochemical methodology for antenatal diagnosis. Significant risks exist in attempting a correct and reliable diagnosis for these disorders.

Metabolic Disorders Diagnosed Prenatally To Date

1. Disorders of Lipid Metabolism
    a. Gm_1 gangliosidosis (Tay-Sachs)
    b. Metachromatic leukodystrophy
    c. Krabbe's disease
    d. Neimann-Pick disease, Type A
    e. Gaucher's disease
    f. Fabry's disease
2. Mucopolysaccharidosis
    a. Hurler's syndrome
3. Aminoacid Disorders
    a. maple syrup urine disease
    b. methyl malonic aciduria
4. Disorders of Carbohydrate Metabolism
    a. glycogen storage disease Type II Pompe's disease
    b. galactosemia
5. Miscellaneous
    a. adrenogenital syndrome
    b. Lesch-Nyhan syndrome
    c. Lysosomal acid phosphatase deficiency

Metabolic Disorders in Which Prenatal Diagnosis May be Possible

1. Disorders of Lipid Metabolism
    a. Gm_1 gangliosidosis
    b. Refsum's disease
2. Mucopolysaccharidosis
    a. Hunter's syndrome
3. Amnioacid Disorders
    a. arginosuccinic aciduria
    b. cystinosis
    c. homocystinuria
    d. hyperammonemia, Type II
    e. ornithine-a-ketoacid transaminase deficiency
4. Disorders of Carbohydrate Metabolism
    a. Fucosidosis
    b. glycogen storage disease, Type III
    c. glycogen storage disease, Type IV
    d. mannosidosis
    e. G6PD deficiency
5. Miscellaneous
    a. orotic aciduria
    b. xeroderma pigmentosum
    c. cystic fibrosis
    d. Marfan's syndrome

D. *Miscellaneous*

Anencephaly and spina bifida has now been diagnosed on the basis of alpho feto protein determinations on amniotic fluid.

Prepared for the Committee on Maternal and
Perinatal Health, Michigan State Medical Society
By Arthur A. Ulmer, MD, Grosse Pointe Shores

References

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W.P.C. News, Wisconsin Perinatal Center, 1972.

The following centers for genetic consultation may be contacted (listed in alphabetical order):

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c/o Lester Weiss, MD
2799 W. Grand Blvd.
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University of Michigan Medical Center
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2015 Holden Perinatal Research Bldg.
Ann Arbor, Mich. 48104 (313) 764-0579

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Shirley Leach, Coordinator
T. Evans, MD, Director

Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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Aurelio Rodriquez, MD
Piyush J. Shah, MD
Paul C. S. Sheng, MD
Souhaila Solaiman, MD
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Recommendations[†] on Combination Live Virus Vaccines

American Academy of Pediatrics

Committee on Infectious Diseases

In the September 15, 1971 *AAP Newsletter* sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."

United States Public Health Service

Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidity and Mortality Weekly Report,* the Advisory Committee on Immunization Practices of the United States Public Health Service presented recommendations on the use of combination live virus vaccines. The committee stated that:

- "Data indicate that antibody response to each component of these combination vaccines is comparable with antibody response to the individual vaccines given separately.
- "There is no evidence that adverse reactions to the combined products occur more frequently or are more severe than known reactions to the individual vaccines (see pertinent ACIP recommendations).
- "The obvious convenience of giving already selected antigens in combined form should encourage consideration of using these products when appropriate."

[†] For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.

M-M-R*

(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

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Given at age 12 months, M-M-R provides for vaccination early in life against measles, mumps, and rubella.

MSD suggested immunization schedule for well babies

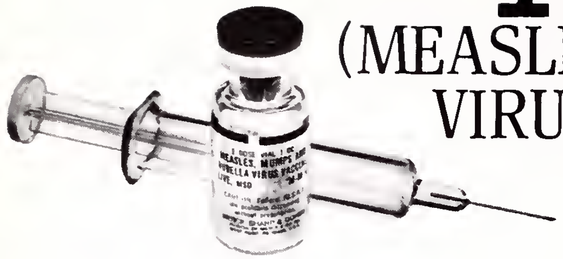
Age	Vaccine(s)
2 months	DPT (diphtheria-pertussis-tetanus) Oral poliomyelitis vaccine (triple)
3 months	DPT[1]
4 months	DPT Oral poliomyelitis vaccine (triple)
6 months	Oral poliomyelitis vaccine (triple)
12 MONTHS	**M-M-R (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE, MSD)**

[1] This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.

Since vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and the vaccine should not be given during the same office visit.

*Trademark of Merck & Co., Inc.

For a brief summary of prescribing information, please see following page.



M-M-R

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Single-dose vials

Contraindications: Pregnancy or possibility of pregnancy within three months following vaccination; infants less than one year old; sensitivity to chicken or duck, chicken or duck eggs or feathers, or neomycin; any febrile respiratory illness or other active febrile infection; active untreated tuberculosis; therapy with ACTH, corticosteroids, irradiation, alkylating agents, or antimetabolites; blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems; gamma globulin deficiency, i.e., agammaglobulinemia, hypogammaglobulinemia, and dysgammaglobulinemia.

Precautions: Administer subcutaneously; *do not give intravenously.* Epinephrine should be available for immediate use should an anaphylactoid reaction occur. Should not be given less than one month before or after immunization with other live virus vaccines, with the exception of monovalent or trivalent poliovirus vaccine, live, oral, which may be administered simultaneously; vaccination should be deferred for at least three months following blood transfusions or administration of more than 0.02 ml immune serum globulin (human) per pound of body weight, or human plasma.

Due caution should be employed in children with a history of febrile convulsions, cerebral injury, or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur 5 to 12 days after vaccination.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Attenuated live virus measles, mumps, and rubella vaccines, given separately, may temporarily depress tuberculin skin sensitivity; therefore, if a tuberculin test is to be done, it should be scheduled before vaccination, to avoid the possibility of a false negative response.

Before reconstitution, refrigerate vaccine at 2–8 C (35.6–46.4 F) and *protect from light.* Use only diluent supplied to reconstitute vaccine. If not used immediately, return reconstituted vaccine to refrigerator at 2–8 C (35.6–46.4 F), and discard after eight hours.

Adverse Reactions: To date, clinical evaluation has not revealed any adverse reactions peculiar to the combination. The adverse reactions that occurred were limited to those that have been reported previously for the component vaccines.

Fever, rash; mild local reactions such as erythema, induration, tenderness, regional lymphadenopathy; parotitis; thrombocytopenia and purpura; allergic reactions such as urticaria; arthritis, arthralgia, and polyneuritis.

Occasionally, moderate fever (101–102.9 F); less commonly, high fever (above 103 F); rarely, febrile convulsions.

Encephalitis and other nervous system reactions that have occurred very rarely with the individual vaccines may also occur with the combined vaccine. Experience from more than 44 million doses of all live measles vaccines given in the U.S. by mid-1971 indicates that significant central nervous system reactions such as encephalitis, occurring within 30 days after vaccination, have been temporally associated with measles vaccine approximately once for every million doses. In no case has it been shown that reactions were actually caused by vaccine. The Center for Disease Control has pointed out that "a certain number of cases of encephalitis may be expected to occur in a large childhood population in a defined period of time even when no vaccines are administered. A survey conducted in New Jersey in 1965 showed that 2.8 cases of encephalitis (of unknown cause) occurred per million children, ages 1–9 years per 30-day period." However, the Center for Disease Control has analyzed the reported reactions following measles vaccines and pointed out that "the clustering of cases in the period 6 through 13 days after inoculation as well as the recovery of measles virus (probably the vaccine strain) from the CSF of one patient does suggest that some of these cases may have been caused by the vaccine." The risk of such serious neurological disorders following live measles virus vaccine administration remains far less than that for encephalitis with measles (one per thousand reported cases).

Transient arthritis, arthralgia, and polyneuritis are features of natural rubella and vary in frequency and severity with age and sex, being greatest in adult females and least in prepubertal children. Such reactions have been reported with live attenuated rubella virus vaccines. Symptoms relating to joints (pain, swelling, stiffness, etc.) and to peripheral nerves (pain, numbness, tingling, etc.) occurring within approximately two months after immunization should be considered as possibly vaccine related. Symptoms have generally been mild and of no more than three days' duration. The incidence in prepubertal children would appear to be less than 1% for reactions that would interfere with normal activify or necessitate medical attention.

How Supplied: Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 $TCID_{50}$ (tissue culture infectious doses) of measles virus vaccine, live, attenuated, 5,000 $TCID_{50}$ of mumps virus vaccine, live, and 1,000 $TCID_{50}$ of rubella virus vaccine, live, expressed in terms of the assigned titer of the FDA Reference Measles, Mumps, and Rubella Viruses, and approximately 25 mcg neomycin, with a disposable syringe containing diluent and fitted with a 25-gauge, ⅝" needle. Also in boxes of 10 single-dose vials nested in a pop-out tray with a separate box of 10 diluent-containing syringes.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

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Michigan authors

Articles

Rodman E. Taber, MD, and Edurado Arciniegas, MD, of Detroit, "An aggressive approach to thromboembolic disease," *Journal of Cardiovascular Surgery,* 14: 306-11, May-June, 1973.

Jay S. Finch, MD, Plymouth, "Pharmacology for the Respiratory Therapist: endocrine drugs," *The Michigan Airway,* 7: 3, 30-31, September, 1973.

James R. Howe, MD, and James A. Taren, MD, Ann Arbor, "Foramen magnum tumors, pitfalls in diagnosis," *JAMA,* 225: 1061-66, Aug. 27, 1973.

Letter

Edgar B. Keemer, Jr., MD, Detroit, "Involuntary Sterilization," *JAMA,* 225: 1658, Sept. 24, 1973.

SMALL DOSES/Continued

injuries, especially occupational primary irritant dermatitis.

Robert E. Rowe, MD, of Port Huron,

has announced his retirement, effective Jan. 18, as director of the St. Clair County Health Department. Doctor Rowe has headed the department for the last 18 years and is a former president of the St. Clair County Medical Society. He plans to move to Cape Coral, Fla.

Roland R. Springgate, MD, of Kalamazoo,

has been elected president of the Michigan Rheumatism Association. Doctor Springgate is vice chief of staff and chief of staff elect of Borgess Hospital in Kalamazoo.

David R. Wall, MD, of Marquette,

has announced that he will resign in January as psychiatric director of the Alger-Delta-Marquette Community Mental Health Center. Doctor Wall plans to continue his private practice in psychiatry and to serve as medical director of the psychiatric unit of Marquette General Hospital South.

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In memoriam

Hans Bergeest, MD
East Lansing

Hans Bergeest, MD, 56, of East Lansing, died Nov. 9. Born in Hamburg, Germany, Doctor Bergeest received his medical education in Germany and served an American internship at Springfield (Ohio) City Hospital in 1957-58. He formerly was college physician for Miami University in Oxford, Ohio, and had practiced in East Lansing since 1967.

Lionel Braun, MD
Pontiac

Lionel Braun, MD, 74, of Pontiac, former chief of obstetrics and gynecology at Sinai Hospital, died Nov. 8. A graduate of the Wayne State University School of Medicine, Doctor Braun had practiced in Detroit for more than 40 years and had served on the staffs of Deaconess and Woman's hospitals as well as Sinai. He was a member of the board of the American College of Surgeons and a life fellow of the American College of Obstetrics and Gynecology. He served as an army medical corps captain in World War II.

Hale W. Cadieux, MD
Benton Harbor

Hale W. Cadieux, MD, 42, an anesthesiologist in Benton Harbor, died Oct. 14. Doctor Cadieux received his medical education at the University of Rochester (N.Y.) and completed residency training at the Indiana University Medical Center. He was on the staffs of Mercy Hospital in Benton Harbor and Memorial Hospital in St. Joseph.

He had served as a navy pilot.

Oswald M. Gruhzit, MD
Black Lake

Oswald M. Gruhzit, MD, 88, of Black Lake, died Oct. 13. Doctor Gruhzit was born in Latvia, but

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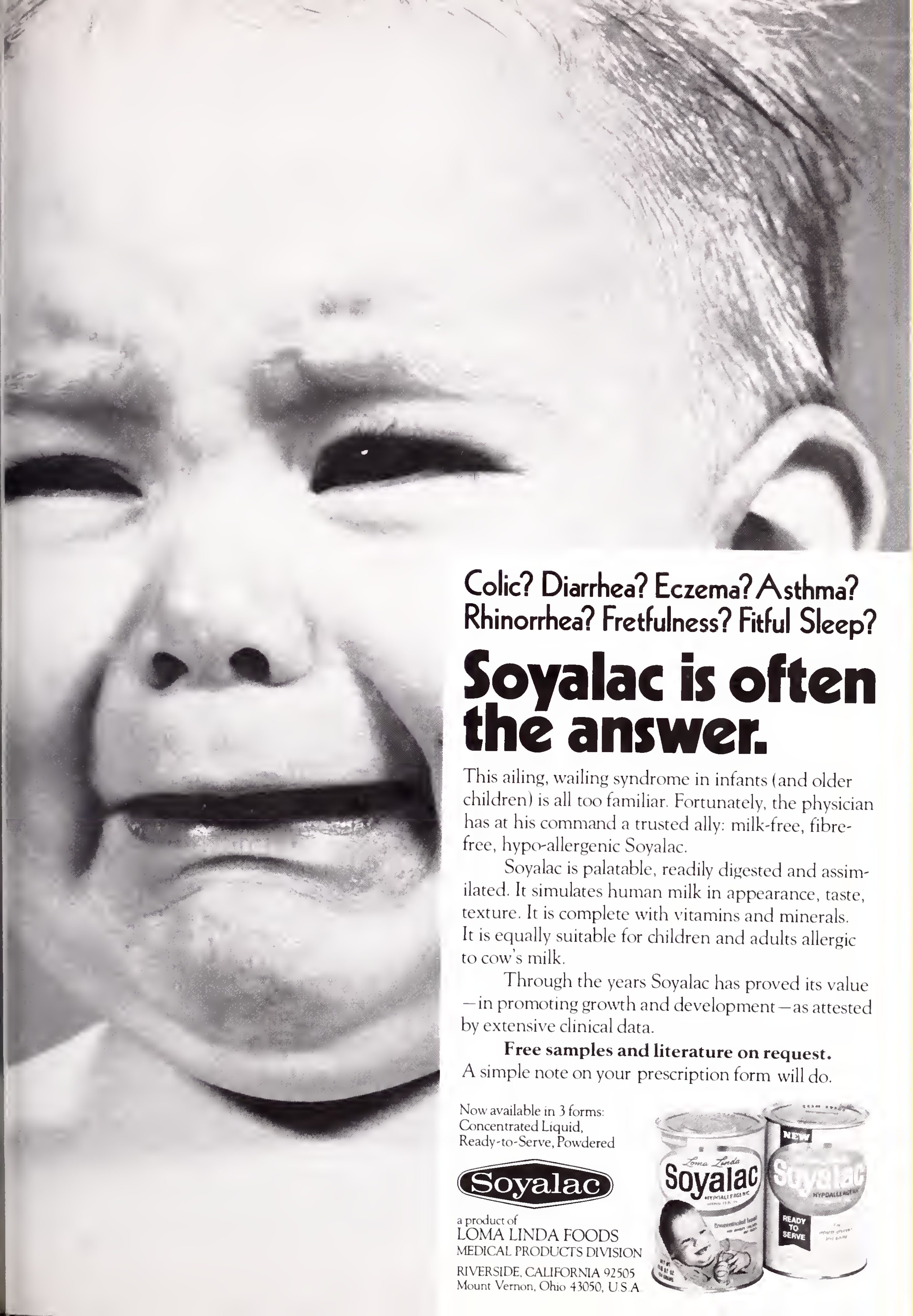

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came to the United States more than 70 years ago and was graduated from the University of Michigan Medical School in 1922. For many years he was in charge of pharmacology and pathology for Parke, Davis & Co. in Detroit and worked on the development of new drugs.

Doctor Gruhzit retired 23 years ago and moved his permanent residence to Black Lake, where he had spent summers previously. Nature study, including the classification of 300 mushrooms and fungi found in the area, political activity and fishing occupied his retirement years.

Manes S. Hecht, MD
Huntington Woods

Manes S. Hecht, MD, a Huntington Woods pediatrician, died Nov. 21 at the age of 66. Doctor Hecht was head of the rheumatic fever clinic at Children's Hospital and was a past president of the Detroit Pediatric Society.

A native of Baltimore, Doctor Hecht moved to the Detroit area 28 years ago. He was a 1933 graduate of the Johns Hopkins University Medical School.

Edward D. King, MD
Grosse Pointe

Edward D. King, MD, 80, of Grosse Pointe, a retired physician, died Nov. 3 in Bon Secours Hospital. Doctor King retired in 1968 after 50 years on the staff of Providence Hospital. He was a graduate of Wayne State University School of Medicine and served as an army lieutenant in World War I.

George E. Kreinbring, MD
Detroit

George E. Kreinbring, MD, of Detroit, died Oct. 20 at the age of 63. Doctor Kreinbring, a graduate of the Wayne State University Medical School and a registered pharmacist as well as a physician, had practiced medicine in Detroit for 33 years. He was on the staffs of St. Joseph Mercy and Saratoga General hospitals.

Alfred D. LaFerte, MD
Grosse Pointe

Alfred D. LaFerte, MD, of Grosse Pointe, a specialist in orthopedic surgery, died Nov. 11 at the age of 87. Doctor LaFerte was a former professor of orthopedic surgery at Wayne State University School of Medicine and had been on the staffs of Cottage Hospital in Grosse Pointe and Harper Hospital in Detroit.

Doctor LaFerte was graduated from the Jefferson Medical College of Pennsylvania in 1910. He served in the army medical corps in France during World War I.

George F. Moench, MD
Sanford

George F. Moench, 74, MD, of Sanford, a specialist in public health and preventive medicine, died Aug. 6. Doctor Moench received his medical education at the former Eclectic Medical College in Cincinnati and also earned a master of public health degree from the University of Michigan.

He was a past president of the Michigan School Health Association, the Michigan Health Officers Association and the Saginaw Valley Public Health Association and a charter member of the American Association of Public Health Physicians.

Frank S. Perkin, MD
St. Clair Shores

Frank S. Perkin, MD, 73, of St. Clair Shores, died Nov. 10. He had served on the Wayne State University School of Medicine faculty since 1928. Doctor Perkin was a past president of the Michigan Epilepsy Center and the Michigan Diabetes Association and represented the United States as permanent advisory vice president of the Pan American Medical Association. He was a fellow of the American College of Physicians.

A native of Grand Valley, Ont., Doctor Perkin received his medical education at the University of Toronto.

Frank J. Sladen, MD
Detroit

Frank J. Sladen, MD, of Detroit, physician-in-chief of Henry Ford Hospital from 1915 until 1953, died Nov. 10 at the age of 91. He had helped direct Ford's growth from a 50-bed hospital to a 1,000 bed institution with a national reputation. After he stepped down as physician-in-chief, Doctor Sladen continued to serve as a consultant in medicine and a member of the hospital's board of trustees.

Doctor Sladen was graduated from Yale University in 1903 and received his medical education at Johns Hopkins University, where he was a student of Sir William Osler.

Doctor Sladen came to Michigan as physician-in-chief at Detroit General Hospital two years before assuming the same post at Ford. He was named layman of the year for 1959 by the Detroit Council of Churches and was honored in 1962 by the Merrill Palmer Institute for "distinguished contributions to the practice of medicine." He served as an officer in the army medical corps.

Frederick A. Sturm, MD
Grosse Pointe

Frederick A. Sturm, MD, of Grosse Pointe, a former Macomb County health officer, died Oct. 30 at the age of 77. Doctor Sturm was a graduate of the University of Michigan Medical School.

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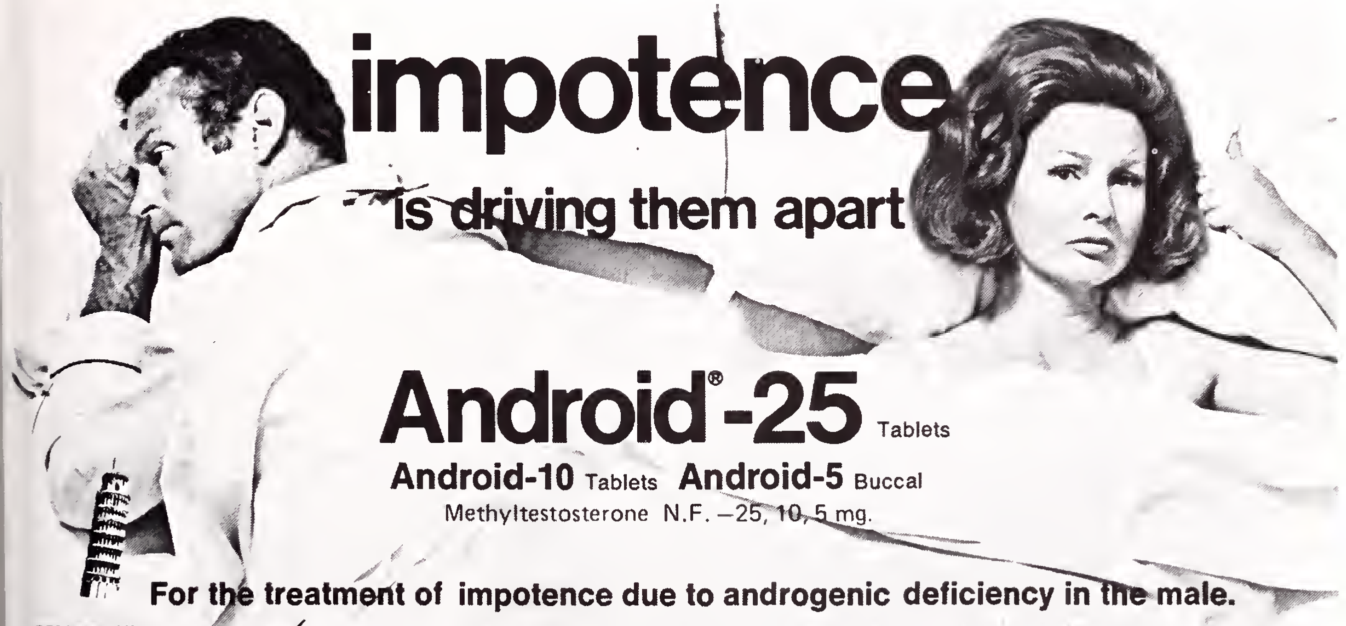

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Each report is followed immediately by the action of the reference committee on that report and then by the House action on the report of the reference committee. Resolutions are printed as they were finally approved or disapproved by the House.

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108th Annual Session
Michigan State Medical Society
October 7-9, 1973

CALL TO ORDER AND SPECIAL REPORTS

1. Call to Order

The Annual Session of the House of Delegates of the Michigan State Medical Society, held at the Sheraton Cadillac Hotel, Detroit, Michigan, convened at 1:30 p.m., Vernon V. Bass, MD, Speaker, and James D. Fryfogle, Vice Speaker, presiding.

2. Invocation

The Speaker called upon the Rev. Paul Sutton to give the invocation.

3. Report of Committee on Credentials

Chairman George F. Poretta, MD, reported 98 delegates seated, the majority of whom were not from any one county.

4. Reports of the Committee on Rules and Order of Business

(a) Report of the Committee on Rules and Order of Business

Chairman Edward E. Elder, Jr., MD, reported that the Committee on Rules and Order of Business held its meeting in East Lansing on Sept. 19, 1973. Vice Speaker James D. Fryfogle, MD, represented Speaker Vernon V. Bass, MD, because he was unable to attend the meeting.

Order of Business for 1973 Annual Session. The Committee amended and approved the Order of Business for printing in the Delegates Handbook.

Action on Late Resolutions. As authorized by the House, this Committee will rule individually on any late resolutions according to their urgency and determine which are urgent and should be received after the deadline for presentation.

Authorization to Recess the House. The Committee again recommends that the House allow the Speaker to recess proceedings to a time certain, without a vote, if need be. We recommend Roberts Rules of Order govern the proceedings otherwise.

Special Notes. The Committee wishes to call attention to the Forums for Delegates at 3 and 4 p.m. on Monday, Oct. 8. At 3 p.m. the subject will be "Professional Standards Review Organizations" and at 4 p.m., "Funding of Graduate Education."

Committee Meeting Time in 1974. We recommend that next year the first meeting of this Committee be held six weeks prior to the meeting of the House of Delegates. This will insure that adequate time is available to make any final modifications in the Order of Business before it goes to the printer.

Recommendation for 1974 Spring Session. Since the 1973 Spring Session of the House of Delegates at Boyne Mountain was well received by the Delegates, the Committee suggests that the Speaker consider holding the 1974 Spring Session in northern Michigan, for instance at Boyne Mountain.

Reports of Officers and The Council. In the past, the reports of the officers and The Council were printed and distributed to the delegates at least a month ahead of the meeting of the House of Delegates. We recommend this procedure be reimplemented. Supplemental reports covering the final action of The Council and officers could be available when the House meets.

(b) Supplemental Report of Committee on Rules and Order of Business

The Committee met again to consider two late resolutions presented to the House of Delegates on Oct. 7, 1973.

The first resolution entitled "Uniform Insurance and Claim Forms." The Committee felt that the Michigan State Medical Society should play an integral part in development of such a claim form as has been stated in previous years' resolutions. The question of the Legislature or the Insurance Commissioner developing the form seemed inappropriate. We recommend that the introducer of the resolution research this further and, if thought desirable, represent it as one of the first resolutions in the spring of 1974.

The second resolution entitled "Medical Society Membership." The Committee was unclear as to the status of the unified membership in Michigan. Our feeling was that this should be researched further and, if appropriate, represented to the House of Delegates in the Spring of 1974.

The Reference Committee did not feel that either resolution was urgent enough to be forwarded to the reference committee already meeting today.

THE HOUSE adopted the report and the supplemental report of the Committee on Rules and Order of Business.

5. Speaker's Remarks—Vernon V. Bass, MD

The Speaker outlined the plans and procedures of the House.

Meeting Site for 1974 Annual Session. The Speaker conducted an advisory poll of the delegates for the site of the 1974 Spring Annual Session and decreed that the 1974 Annual Session will be held at Boyne Mountain on May 5-6-7, 1974.

Election Procedures. The Speaker recommended that the House implement the changeover from a fall annual session to a spring annual session by extending the terms of all officers and councilors following the Fall 1973 election to the Annual Session in 1975.

REFERENCE COMMITTEE B, John W. Moses, MD, Chairman, recommended approval of the Speaker's recommendation re election procedures that in implementing the changeover from a Fall Annual Session to a Spring Annual Session, the terms of all officers and councilors be extended to the Spring Annual Session in 1975.

THE HOUSE approved the recommendation of the reference committee.

Resolution 72A-2 "Physician Service in Outpatient Departments" and Resolution 72A-19 "Exploitation of Physicians." The Speaker announced that these two resolutions, which were referred to the Judicial Commission in the fall of 1972, have been referred back to the Speaker of the House of Delegates.

THE HOUSE adopted a motion that these resolutions be resubmitted and brought to the floor at the 1974 Spring Annual Session.

(The following report of the Speaker was presented to the delegates in printed form.)

Speaker's Report, 1973 Spring House of Delegates

This is a brief review of the implementation of resolutions adopted by the 1973 Spring House of Delegates. (For complete text of resolutions with House Action, refer to the Digest of Proceedings, *Michigan Medicine*, Vol. 72, No. 24)

No action was taken on Resolutions 73S-5, 73S-12, 73S-18, 73S-23, 73S-25, 73S-40 and 73S-42. Resolutions 73S-11, 73S-17, 73S-20, 73S-26, 73S-28, 73S-30, 73S-32, 73S-33 and

73S-35 were disapproved and Resolution 73S-38 was withdrawn.

73S- 1 — *Of Commendation to Ingham County Physicians Who Care for Legislators.* A copy of this resolution commending Ingham County Medical Society members who care for legislators was presented to the officers of the Ingham County Medical Society at its June meeting by Brooker L. Masters, MD, MSMS president elect.

73S- 2 — *Shortage of Family Physicians.* Letters were mailed to the deans of three medical schools calling the resolution to their attention. The resolution was referred to the MSMS Education Liaison for possible further follow through. The Michigan Academy of Family Physicians was notified of this action.

73S- 3 — *Name Change for Section on General Practice.* Bylaws changes to effect the intent of this resolution, changing the name of the section to the Section of Family and General Practice, were approved on first reading this spring and will be given final consideration at the Fall 1973 Session of the House of Delegates.

73S- 4 — *Name Change of Medical Auxiliary.* This resolution which encourages the "Woman's Auxiliary to the Michigan State Medical Society" to consider changing its name to the "Michigan State Medical Society Auxiliary" will be considered at the Auxiliary Annual Convention on Oct. 9 and 10, 1973, in Detroit.

73S- 6 — *MSMS Deductible Health Insurance.* The MSMS Council at its meeting on Aug. 3-4 adopted the Blue Cross/Blue Shield Econo Plan, which is now available to MSMS members participating in the Blue Cross/Blue Shield 94000 Group on an individual option basis. The coverage will be effective Nov. 1, 1973.

73S- 7 — *On Determining Physician Fee Profiles.* This resolution, which requested that Blue Shield and other insurance carriers abandon setting physicians' profiles, was transmitted by letter to Michigan Blue Shield and the Health Insurance Council.

73S- 8 — *Chiropractic Practice in the State of Michigan.* This resolution was referred to the MSMS Committee on Public Relations for follow through. The resolution came from that Committee and represented a tentative educational program to reach physicians and the public. The resolution had been introduced by Richard Gascoigne, MD, delegate and chairman of the chiropractic task force of the Committee on Public Relations. Each component society has been requested to appoint a "resident expert on chiropractic" to serve on the special MSMS task force. One workshop was held this spring for these doctors and a second is planned for the fall. As the first major step to inform doctors about chiropractic, a special four-page feature section about chiropractic appeared in the July issue of *Michigan Medicine.* Activities are described also in the 1973 Annual Report of the MSMS Committee on Public Relations.

73S- 9 — *Presence of Physician at Blood Collecting Clinics.* After several years of effort with the Department of Public Health, new rules governing blood collection in Michigan were promulgated and took effect June 15, 1973. One new provision is that Blood Banks can receive from the Department of Public Health authority to function without a physician on the premises if an alternative plan is satisfactory. This alternative plan must provide that the physician is on call and available within a fixed period of time. The objective of Resolution 73S-9 has been accomplished.

73S-10—*Size of Malpractice Awards.* Members of Michigan's Congressional Delegation have been made aware of House Resolution 5052, introduced by Congressman Robert Huber. The AMA Legislative Liaison staff of Washington also is aware of this bill. Prospects for this specific bill, which would place limitations on professional liability findings, are not believed good. However, the presence of the bill, along with other legislative efforts at the state and federal level to resolve the malpractice problem, indicates a growing concern by public officials of the problem. Legislation to attack the professional liability problem has been offered both in Michigan and in Washington.

73S-13 — *Change in Annual Session.* This resolution directed that the Annual Session of the House be held in the spring with the Speaker having the option of calling a Fall Session, if necessary. It was referred to the Constitution and Bylaws Committee but subsequently it was determined that no Constitution or Bylaws changes were required and the change will be implemented beginning in 1974.

73S-14 — *Malpractice Screening.* This matter is being investigated by MSMS Legal Counsel and liaison has been established with the Legislative Service Bureau, who in turn will investigate arbitration systems in other states. The results of these investigations will be communicated to the House of Delegates when a meaningful determination can be made.

73S-15 — *Blue Cross Hospital Payments.* Substitute House Bill 4518 had been introduced in Michigan's Legislature at the time the House of Delegates acted on this resolution. In effect, the resolution provides that the patient should have the same right to select hospitals under Blue Cross as they have a choice of physician under Blue Shield. The Governor has signed the bill into law authorizing Blue Cross to participate with proprietary and the for-profit hospitals. The bill is permissive and does not force Blue Cross to contract with all proprietary hospitals. Blue Cross quality control criteria will be used in determining which hospitals it recognizes.

73S-16 — *Relief from Governmental Economic Controls.* Members of the Health Care Advisory Committee of the Economic Stabilization Program have been made aware of the Michigan State Medical Society policy that the guidelines on physicians' fee increases are unfair and discriminatory. Evidence outlining the increased overhead costs of a physician's practice have been sent to the Committee. Further communications urging changes in the law will be addressed to the Committee and the government.

73S-19 — *Inequity and Discrimination of Phase III of the Government's Wage and Price Controls upon Physicians.* Substitute Resolution adopted in lieu of Resolutions 73S-16, 73S-19 and 73S-24. See Resolution 73S-16.

73S-21 — *Medical Records as an Insurance Document.* This resolution urged that Blue Shield define what documentation of medical services is required by the provider at hospitals and teaching institutions. It was transmitted by letter to Blue Shield and referred to the MSMS Liaison Committee with Michigan Medical Service.

73S-22 — *Necessary Medical Examination versus Screening.* This resolution, regarding the physician's right to determine the necessary pre-operative tests for patients and opposing retrospective review by lay corporations such as Blue Shield, was transmitted by letter to Blue Shield and referred to the MSMS Liaison Committee with Michigan Medical Service.

73S-24 — *Physicians' Fees in Phase III.* Substitute Resolution adopted in lieu of Resolutions 73S-16, 73S-19 and 73S-24. See Resolution 73S-16.

73S-27 — *Notification for Formal Hearings.* Bylaws changes to effect this resolution's direction re procedures of notification in formal complaints were adopted on first reading at the Spring House of Delegates Session and will be presented for final consideration this fall.

73S-29 — *Malpractice Legislation.* MSMS, through *Medigram*, its legislative report, and the monthly Journal, intends to inform members on legislation introduced affecting the malpractice problem. One thus gained this Spring was legislation relieving physicians, hospitals and blood banks from liability in transplant procedures except for wilful misconduct or negligence. Legislation has been introduced in the Senate to amend the Statute of Fraud to require written warranties in breach contract cases (SB 809). Senate Bill 489 would accomplish the objectives of the second Resolve relative to burden of proof and the Affidavit of Merit.

73S-31 — *MSMS Liaison Committee with Michigan Department of Social Services.* A new liaison committee has been organized (see report on Medicaid). The Committee was structured to reflect representation of physicians with major medical Medicaid patient loads and billing experiences. The Department of Social Services welcomed the creation of this permanent committee to continue liaison and the first meeting was held with the Director of the Department and the Director of the Medicaid Program within the Department on Aug. 29, 1973. A report subsequently was submitted to The Council on Sept. 19.

73S-34 — *Insurance Forms.* This resolution directed that MSMS work toward a standard invoice form and standard nomenclature. A resolution on the latter subject was introduced at the AMA Annual Session in June of 1973 and the AMA is working on both these problems.

73S-36 — *Blue Shield Agreements.* This resolution, which was referred without action to The Council for further study and action, resolved that Blue Shield should rescind any requirements for signed agreements by physicians. The Council has referred the resolution to the MSMS Committee on Utilization Review.

73S-37 — *Fiscal Notes on Reports and Resolutions.* This resolution requires that when appropriate future reports and resolutions presented to the House of Delegates shall include a fiscal note and this new requirement has been communicated to members of the House of Delegates in the advance mailing which announced the deadline for submission of resolutions.

73S-39 — *Medicaid Performance, Surveillance & Utilization Report System.* This resolution requested MSMS consultants to this project to submit reports to The Council and to component societies if indicated. Although the consultants have been relatively inactive recently, a report was made to The Council in August and an informational mailing went to The Council and component society officers regarding recommended lengths of stay.

73S-41 — *Abortions.* To accomplish the various resolves of this resolution, MSMS has gone on record on several occasions in support of the guidelines promulgated by the Department of Public Health. In addition, MSMS Council has supported SB 345 which would give legal enforcement powers to the guidelines, which at this point in time are guidelines only without enforcement capability. The time periods, particularly in the second resolve has been fairly well recognized throughout the State. The Department of Public Health would receive inspection and approval authority under a number of pieces of legislation now before the Michigan Legislature. The Committee on Maternal and Perinatal Health has involved itself with several other organizations in an effort to achieve quality control in an area where the concept of abortion as a medical procedure has been established relatively well, but quality control is not established in Michigan. Medicaid and Blue Shield pays for abortions that conform with the guidelines of Public Health.

6. President's Address—John J. Coury, Jr., MD

Just one year ago—and it seems like yesterday—I assumed the Presidency of this great Michigan State Medical Society.

I can assure you it has been the fastest moving, and most rewarding year of my medical life.

One cannot serve in this position and not appreciate the devotion and efficiency of all of our headquarters staff, who provide the administrative skills to implement the policies and directives of the House and The Council. And I am awed too by the dedication to organized medicine and patient care of your officers, Councilors, House leaders, committee members, AMA delegates and alternates.

You are to be commended for the people you select to represent your Society.

I wish to give particular thanks to Bob Leitch and Brooker Masters for their assistance and support during this challenging year. Without them my task could not have been half the fun that it was.

We also owe a deep appreciation to our very able Medicaid Liaison Committee that so ably resolved the almost impossible. They deserve your support for their very difficult task.

I also salute those men who are doing such a great job in trying to make some sense out of PSRO.

I could stop here but must extend the Society's appreciation to Governor William Milliken for his sincere interest in quality health care and to his very able and concerned advisor Doctor Donald Smith. Michigan is fortunate indeed in having men of their concern and caliber.

Much of my time this year has been devoted to being a member of the Governor's Health Advisory Planning Council plus participating in an important seminar of three days on "Major Issues and Trends in Health Care Services," in commemoration of the 100th anniversary of the Michigan Department of Health.

I represented MSMS before many groups including a session about licensing of professionals held by the Michigan Association of the Professions.

Let me assure you these activities have been highly educational as well as time consuming.

Much has been learned by yours truly this year and I would like to give you my thinking on major issues before us and to which we must respond.

PSRO

Despite the objection of some members of our Society, I feel that we are "on top of the issue." We must continue to proceed to develop an organizational plan and push forward to control our own destiny. If we do not, then I can assure you we will be controlled by a bureaucracy. Many outside organizations are working tirelessly in an attempt to take over peer review. These groups include the Comprehensive Health Planning Agencies, Hospital organizations, insurance companies, and governmental organizations.

What position are you desirous of being in, in the future—peer review or bureaucratic regimentation?

The choice is yours! Let it not be said in the future that we sank our own ship!

CONTINUING MEDICAL EDUCATION

CME is a must for quality medical care—a prime responsibility of every member of our profession. The majority of you are assuming this responsibility, but you have an added one. You must encourage these of our profession who are not assuming this responsibility to get it. They are our Achilles Heel.

MALPRACTICE

Unfortunately the President's Commission on Malpractice came up with a voluminous and hollow report. It refused to come to grips with the real issues. Medicine accepts its responsibility for a share of malpractice, but an equal sharing must be borne by the legal profession and the patient. The cost and fear of malpractice suits have brought on much defensive medicine which is a great factor in the increased cost of medicine, at least 15-20% by most reliable sources. We must demand and achieve fair play! The public must demand it! This Society *must* continually strive to find a solution—legislative or otherwise. Hopefully the keen minds and hard work of our members will eventually pioneer a solution in Michigan and in the nation.

UNITY

On many previous occasions I have pleaded for greater unity within the profession. I continue to plead, but more strongly than ever before. My experiences during this past year confirm my impression that our survival as a viable organization of the future will result only if we are a highly-unified profession able to speak authoritatively for our members.

No longer can we bathe in the luxury of complete individualization at the expense of the profession as a whole.

We cannot tolerate the factionalism between the generalist and the specialist, between the rural and the urban, between the practicing and the academic, between the black and the white, and between the young and the old. We have the common goals of quality health care—and of mutual respect. We have the first, but where is the other?

Let me assure you, from my experiences the past year, I am convinced there are strong and viable forces here in Michigan that are dedicated to changing our entire system of health delivery. They are organized, dedicated to their cause, financed, and able.

We must be ever mindful that unity includes also a strong local county society, a strong MSMS, and a strong AMA.

PROVIDER CONFERENCE

This I have saved for last, in fact it was the last major activity in which I participated prior to this meeting. Having spent a 3-day closed session with many and varied providers of health services, I came away with the impression that there was a common lack of knowledge about the efforts, programs and goals of each other. There is a fragmentation and overlapping of goals—though the purpose in many instances was a common one. The method that some are using to achieve these goals was at times frightening.

I could only conclude that there must be a knowledgeable and common understanding of each position of each provider in health care delivery, be it public or private. Only with this knowledge can we really understand our position in society and chart our course for the future.

This morning, in my final remarks to The Council as President, I discussed this very matter in greater detail. I recommended to The Council and they concurred that it stimulate and initiate a Dutch treat workshop with all providers of health care—public and private, in the near future. During this workshop we will talk *with* each other rather than talk *at* each other, and put on the table the plans and objective of each.

Again, may I thank you for permitting me to be your President this past year. It has been an honor to represent such a great profession.

Rewarding, challenging, tiring, exhilarating, frustrating, but so worthwhile.

REFERENCE COMMITTEE B, John W. Moses, MD, Chairman, considered the remarks of the President, but inasmuch as there are no recommendations, recommended the report be accepted for information.

THE HOUSE adopted the report of the Reference Committee.

7. President-Elect's Address—Brooker L. Masters, MD

> "Happy are those who dream dreams and are ready to pay the price to make those dreams come true."

Mankind has always dreamed, for without visions, there would be no progress. Great have been the visions of the men and women of medicine, for their dreams have been of a future free of pain, free of crippling, free of disease.

But new challenges and new problems face us today. I come to this office, not to dwell on the dreams nor the accomplishments of the past, but to pierce the veil of the future and to shape our dreams for the year to come. But in that year, I cannot promise an endless succession of triumphs.

A famous person once said, "I have nothing to offer but blood, toil, sweat, and tears!" And to this I must add "frustration and challenges." For this is the year 1973 in Michigan, and it is about the medical care system that I address you tonight.

The year to come is fraught with multiple problems. Questions demanding an answer and challenges that boggle the mind. But the dream does not die! Amid the problems is the inspiration that calls us to serve mankind in an ever more meaningful manner, the dream that medicine will once more assert its right as the guide to man's struggle to build a better world for all to enjoy.

And that dream can come true if we are willing to pay the price. Beyond the frustrations and the challenges lies the dawn of that better world. That dream can come true because you are the representatives both of our great profession and the Michigan State Medical Society.

Throughout my remarks to you tonight, please keep in mind the great possibility that our dreams can come true—if we are willing to pay the price.

As we survey the problems of medical care delivery, foremost among them is the issue of our sensitivity and responsiveness to patient needs, desires, and demands. The time is past when physicians could operate from the level of Mount Olympus relying upon a mystique alone to hold the patient enthralled. As our knowledge and control of the forces of disease have increased, so has our aura of impregnability decreased. If medical science and training have made great strides in the past quarter century, so also have the sophistication and knowledge of the patients we treat. The father-deity approach will no longer suffice. Patients now consider it their rightful heritage to receive the benefits of medicine's great scientific advances.

Health is the cornerstone of the good life. For without health, life means little, and the good life is *the* life for all. Unless we understand and accept this concept of equal health opportunities for everyone; unless we react sympathetically to developing patient attitudes of personal worth and dignity; unless our medical schools instill in budding physicians a real sensitivity to the needs of the public, our opportunities to direct health care will be diminished if not eliminated.

We frequently remark that in the face of rising public demand and at a time of shortage of personnel, the public and the public's elected representatives must act generously and responsibly. But charity begins at home! As members of the House of Delegates and The MSMS Council, what can *we* do to improve the delivery of health care in Michigan? To be sure, you will say that we have already been delivering health care to the people of Michigan for 108 years. But we must work in new areas today.

Social issues of the present cannot be met with the responses of the past. The winds of change blow strongly, and we must bend with the wind, or we must fall under the force of the blast. We must study the issues; we must prepare plans of work. And most of all, we must convince all doctors to accept more responsibilities in this new area.

We are all aware that many areas of Michigan do not enjoy adequate medical coverage. Specifically, we need more family physicians, and we need them more equitably distributed. In my home county of Newaygo, we have one doctor for every 3000 people. In one of the neighboring counties, not so rural, the ratio is one doctor to every 200 people. And if the needs of rural counties are inadequately met, certainly the medical care of the inner cities is more inadequate still.

Doctors of all kinds are in short supply there, but family doctors, especially, are urgently needed. Certainly the people of Michigan and their legislators feel this need for more family doctors. In 1972 there were 48 doctors in family practice residency programs in Michigan. At the same time there were 341 in general surgery residencies. Who in Michigan should decide how many specialists we train and how many primary physicians, or where we train them? If the medical profession and the medical centers cannot come to grips with this inequity and take steps to reduce it, we will forfeit our right to do so.

But there are other gaps in quantity of care. Given the doctors we need, and in the places we need them, too little attention is still given to preventive care. We must intensify our efforts in child health, nutrition, immunization, etc. And while MSMS is doing this, we must convince our patients that they too have some individual responsibilities for their own good health. Obesity, alcoholism, drug addiction are the doctors' anathema because there is no treatment, no magic potion that can solve these problems. Only the patient himself is responsible for these diseases and he must be told so.

We must influence the medical schools to modify the attitudes that their training instills in students. In our day we were trained to be individualists, go our own way, and everyone else be damned! Those days are gone.

Today's doctors must be trained to work effectively with the growing numbers on the health team. We are no longer lonely paragons working in solitude. Young physicians must learn to captain the team so that under competent direction, the many para-medical personnel may fill the present void of health care. And I repeat they must be aware of their patients as individuals. I challenge the MSMS Education Liaison Committee to do more than provide a common meeting ground for town and gown, but to play a stronger role in providing guidance, and of challenging the deans to respond to concerns to be identified by practicing doctors.

The three component societies with medical schools in their counties have untold opportunities to find new ways of working effectively together.

Having considered the problem of quantity of medical care, let us now turn to quality. There is presently a loud hue and cry for "quality medical care." What does this mean? What is quality care? How do we measure it, and who shall do the measuring? It seems obvious that only those who are trained in medical care are competent to judge the quality of such care. Unfortunately, we have been reluctant to exercise control in this respect. The Hippocratic Oath states that all physicians are brothers, and we have been blinded by the beauty of this brotherhood. Our responsibility has always been, and always must be, to our patients.

We doctors of medicine and osteopathy must review our quality control measures, and we must make them work better. If we do not monitor the quality of care, some lay group will do it for us. Almost daily some new report is released, floating grandiose ideas of how these groups would go about it. We must not default this responsibility! The percentage of incompetent physicians is small. Our overriding responsibility is to place the public good above our personal reluctance to act.

The proposed new Michigan medical practice act would give the state new tools with which to attack this problem. We must actively support the adoption of this act by the state Legislature.

Hand in hand with these efforts must go refinement of our approaches to continuing medical education. Those of us who have worked with recent graduates of the medical schools are sharply impressed with the advances being made almost daily in medical treatment. As we pursue our busy schedules, time must be allotted and opportunities must be offered for further training in these advances. Here again, the profession must move in responsible ways, or others may be writing the examinations that we must pass for relicensure.

But beyond the problems of quantity and quality of care is the cost of that care. In 1974 I will work hard to explain to lay groups and others the many ramifications of medical care costs. The public must be told that from the high costs of the Medicaid program, only 13 cents of every dollar is paid to the physician. Our profession must not absorb all blame for rising health care costs. The same labor unions or teacher's associations that strike for higher wages must be made aware that the thousands of hospital workers in Michigan have the right for better salaries too, and that those salaries form a major part of medical care expense.

The wild schemes for national health care promise everything with little mention of cost. Somehow the public must be made aware that "there ain't no free lunch, and never was." At the same time, we must find a way to ease the worst financial burdens of illness. MSMS must study the many approaches to government medical care programs and find one that will help solve the problems of chronic illness and catastrophic health problems. The affluent can handle these emergencies; and the Medicare and Medicaid programs help the disadvantaged; but in my home town the factory workers, the clerks, and the farmers cannot pay for catastrophic illness without financial ruin.

Third-party payors are here to stay, but we must take a stronger role in determining by which ground rules we will play the game. It was a year ago that this House of Delegates decided to negotiate with the State Department of Social Services in regard to some of the machinery being established for the Medicaid program. With that decision MSMS proved a viable force. Changes were made so both the public and the doctors were better served.

As we talk about the costs of medical care, we should ask, "What is a life worth?" If that life is yours, or that of a member of your family, there is no limit to the value you will place upon it. You want the most sophisticated medical care that is available. Such care *does* cost more. Complicated medical equipment and specially trained personnel are vastly more expensive than a helpless, hopeless vigil beside the sickbed. Likewise, new and efficient drugs cost more than aspirin, but their efficacy is such that the worker can be returned to his job more quickly, with less loss of pay. Many examples could be given of rehabilitation programs that restore people to richer and fuller lives, but all these programs cost immensely more than when we had nothing with which to help.

MSMS has a relatively new Bureau of Economic Information that is producing new studies. Using this information some of our committees can now move forward on a solid footing. To help more doctors deal effectively with the economic aspects of quality medical care, I urge every component society to accept the MSMS offer to provide speakers and programs for component meetings.

These, then, are some of the problems which face us in the coming year. How can we best approach their solution? No profession has as many potential leaders and problem-solvers as we have in medicine. Medical students are carefully screened before they are accepted, and their success depends upon discipline, initiative, and hard work. Facing the basic issues of life as we do, doctors are aware that the problems listed tonight, and many more, cry out for viable solutions. The question continues to be: How can we motivate more doctors to accept positions of leadership? How can MSMS train future leaders? How can we involve more of the younger doctors?

MSMS must find ways of asking our members what *they* think. What are their opinions? It is not enough to direct information *at* the members; we must find new ways to listen. Every member of the House of Delegates and The MSMS Council must work every day at improving the two-way communications between MSMS and the individual physician, whether or not he happens to be a member.

In addition, those of us in private practice realize that MSMS must include the views of the doctors in the medical schools, those in public health, those in research labs. We must all work together to resolve the concerns of every licensed doctor of medicine in Michigan, and every student in the medical schools.

MSMS must involve more students and house staff members in positions of decision making. We must be concerned with the minorities. I am personally pleased with the progress MSMS has made in working cooperatively with the black physicians, with those in the medical schools, and with those in governmental positions.

There is great need for unity! But unity must not come in the form of new organization that resembles the labor unions, for that would not represent all our points of view. And the idea of responding to ultimatums from labor bosses is very foreign to our training and principles. No, unity must not equal conformity.

One of my major goals this coming year will be to work for greater unity within our profession. Once this is accomplished, then we may begin to work more effectively with non-medical groups. During the year I hope to address a number of other allied professional groups, presenting our views and seeking ways of working constructively together for the good of all. This is part of the dream.

The greatest enemy to the accomplishments of our big dream is our own apathy. We cannot afford the luxury of the status quo. You know the boat is being rocked. If we do not face the health problems in a positive, creative, aggressive manner, then others will do it for us. Our founding fathers believed that government exists for the purpose of giving order to society. The inability of private enterprise to squarely face today's problems has given birth to the idea that government exists to order society. For 108 years, we have had freedom in the practice of medicine, but today we stand in daily danger of losing those cherished freedoms.

I know that Doctor Coury has done a truly tremendous job with many groups outside of medicine, and certainly within the medical profession in Michigan and on the national level.

I certainly believe that each MSMS president has contributed something special in our dream of a stronger profession and a healthier public.

As your new president, I have the opportunity to help shape our dream of a better future.

I will listen to your ideas.

I want to set some goals to shape that dream.

I want to change these goals if new opportunities become more important.

I urge each of you to pledge your support, your assistance, your devotion to high ideals.

Let us dedicated physicians dream—and build—together toward a better world for all mankind.

> "Happy are those who dream dreams and are ready to pay the price to make those dreams come true."

8. Report of the Judicial Commission—Robert J. Mason, MD, Chairman

During the past year, the Commission has met quarterly at MSMS headquarters. Attendance has been excellent and the entire Commission membership has been very responsive to the questions presented and the deliberations of the group.

Procedures have been promulgated previously by this Commission for handling matters that are directed to the Commission for consideration. These requests for guidelines, information and decisions come primarily from component medical societies. However, there is a great increase in the number of requests from individuals, both physicians and lay people. Many complaints from individuals are originally directed to the AMA, the Board of Registration in Medicine, or even the Governor, in addition to the State Society. Usual Commission policy is to refer these complaints to the component society of the physician involved for primary action, even though by so doing we sometimes lengthen the time it takes to respond to the complainant in a satisfactory manner.

Because of the complexities of medical practice and all its ramifications in the world today, the Judicial Commission is establishing guidelines and new philosophies as to the type of complaints that will be received by the Commission from various organizations and individuals. An increasing number of requests are received from lawyers, asking for rulings on the relationships between physicians and corporations. Many complaints are not accepted because they do not concern an ethical question with regard to an individual physician, or a question of general impact.

Another project of the Commission is the compilation of a handbook of decisions handed down by the Commission since its establishment. This booklet will be similar to the one published periodically by the AMA Judicial Council.

9. Report of the Michigan Delegation to the American Medical Association—Donald N. Sweeny, Jr., MD, Chairman

The Annual Convention of the AMA was held in New York City, June 24-28, 1973.

The Michigan Delegation met each day at a breakfast caucus to discuss the business of the convention.

For clarity, the highlights of the House of Delegates actions are presented in five sections as follows:

I. ELECTIONS

A.

President-Elect	Malcolm C. Todd (California)
Vice President	Bryce Robinson (Alabama)
Speaker, House of Delegates	Tom Nesbitt (Tennessee)

B. Conference of Presidents and Other Officers of State Medical Associations of the AMA—George Slagle, MD, President-Elect.

C. Candidate John Moses, MD, from Michigan for Council of Medical Education was defeated on the third ballot.

D. Interns and residents membership on Council.

A seat will be provided on the Council on Medical Service and the Council on Medical Education for a representative from the Resident-Intern members of the AMA.

E. A committee on House Staff Affairs was established. This is intended to strengthen intern and resident participation in organized medicine and to advise the Board of Trustees on matters of special concerns to House Officers.

II. MATTERS PERTAINING TO PHYSICIANS AND GOVERNMENT

A. *PSRO*

Two reports from the Board of Trustees outlined the AMA activities to provide input into PSRO regulations by HEW.

Two resolutions were adopted clarifying the AMA position concerning PSROs as follows:

(a) Inform HEW that only practicing physicians are qualified to carry out peer review.

(b) Existing peer review groups should not be disbanded.

(c) AMA must oppose any regulations which lead to the deterioration of quality care and if necessary act to have PSRO repealed.

B. *WAGE-PRICE CONTROLS*

The Board of Trustees was instructed to work by all lawful means to assure non-discriminatory treatment of physicians under present and future economic stabilization programs.

C. *FDA REGULATIONS*

The AMA Board of Trustees was directed to protect proposed and current regulatory activities of the FDA which have the effect of restricting use of prescription drugs to "official Library."

In addition, the AMA was mandated to work closely with the FDA to develop a more effective system of communicating the views of practicing physicians and medical specialty societies when action is proposed that may result in removal of frequently prescribed drugs from the market.

D. *UNIFORM CLAIM FORM*

The C.M.S. was encouraged to renew its efforts to devise a uniform claim form to be used by private and government insurance groups.

The various third party insurance agencies (private and governmental) were encouraged to adopt the 3rd edition of Current Procedural Terminology to identify and report physician services. (Mich.)

III. MATTERS PERTAINING TO PHYSICIANS AND HOSPITALS AND MEDICAL SCHOOLS

A. *QUALITY ASSURANCE PROGRAM (PEER REVIEW OF HOSPITAL CARE)*

This program of the A.H.A. was thoroughly debated and the Board of Trustees was directed to meet with the A.H.A. to offer its suggestions and reservations.

B. *SUPPORT FOR MEDICAL STAFFS*

Lengthy debate was held over protests of unilateral changes in medical staff bylaws by hospital boards of trustees that usurp the prerogatives of hospital medical staffs.

It was resolved:

1. Proposals between Hospital board and medical staff must conform with principles of medical ethics of AMA.
2. Unilateral changes in medical staff bylaws by Hospital Boards of Trustees are improper.
3. The following preamble should be included in all medical staff bylaws:

"The hospital and the medical staff have a duty to cooperate in their mutual responsibility of assuring the high quality of patient care standards within the hospital. Only physicians can practice medicine under the laws of the state. In those areas in which medical judgment and the evaluation of professional competence are involved, the hospital has a duty to rely upon the judgments and recommendations of the medical staff, to cooperate and to provide needed assistance with full understanding that the primary responsibility is that of the medical staff."

C. *HOSPITAL BOARDS*

The House voted: 1) increased medical staff representation on hospital Boards 2) State and local medical society efforts to remove barriers to such representation and 3) JCAH be charged to ascertain the effectiveness of communication between hospital and governing boards and their medical staffs.

D. *CERTIFICATE OF NEED LAW*

The AMA urges that voluntary planning preserve decision making at the local level with final authority within a board which includes representation of physicians in the active practice of medicine.

E. *TEMPORARY LICENSURE FOR PHYSICIANS IN DEPRIVED AREAS*

Some medical societies were encouraged to support amendments to medical licensure laws to permit out-of-state physicians to practice temporarily in areas of medical need.

IV. AMA AND INTERNAL AFFAIRS

A. *UNIONS*

The House reaffirmed the tradition of the medical profession of not withholding medical services or performing any act interferring with public welfare. The delegates also opposed unionism among self-employed physicians although it recognized that physicians in employment situations needed special support and assistance.

B. *MALPRACTICE*

The House approved the formation of a Medical Liability Commission to represent health care providers in dealing with medical malpractice problems. Representations are from AMA, AHA, ACS, ACP and four specialty societies. This commission will move in September 1973.

C. *SEPARATION OF BUSINESS AND SCIENTIFIC MEETING*

The House adopted a policy that a scientific meeting be held each year in conjunction with the Annual Convention Board that one or more additional meetings of the Scientific Assembly be held each year at times and places selected by the Board of Trustees. Such meetings might or might not conjoin with the clinical meeting of the House of Delegates.

The House rejected the proposal that all House of Delegates meetings be held in Chicago and all existing meetings of the House and Scientific Assembly scheduled through 1976 will not be changed.

D. *ELECTION OF TRUSTEES*

The House rejected a proposal that election of Trustees be on a geographic basis and instructed that a Bylaw change be drafted for the 1973 Clinical Meeting to limit Trustees to two 3-year terms.

E. *MEMBERSHIP CERTIFICATION AND DUES*

"Physicians shall become members of the AMA upon certification by state medical societies rather than by AMA receipt of dues.

"The delinquency date for remittance of AMA dues is changed from June 1 to April 30 of each year, and the requirement that members who have been dropped for non-payment of dues must pay one year's past dues is eliminated.

"The criteria for exemption from AMA dues shall be consistent with exemption from state medical society dues, except that members reaching their 70th birthday may apply directly to the AMA for Active Dues Exempt Membership status.

"Elimination of the requirement that AMA membership be limited to those physicians in military service whose tour of duty is two years or more. Younger physicians serving two years or less in the military or the U.S. Public Health Service will be eligible for AMA membership, and county and state medical societies are encouraged to adopt this procedure."

V. MISCELLANEOUS

A. *ABORTION*

The House of Delegates emphasized the professional "positive attitude toward life itself" and the alternatives to abortion. It reaffirmed the policy adopted in 1970 that abortion should be performed in accordance with "good medical practice, the exercise of sound clinical judgment, informed consent and evaluation of the patient's medical and emotional needs."

B. *MICHIGAN RESOLUTIONS ADOPTED:*

1. Establishment of Health Councils in all states referred to Board of Trustees for implementation.
2. Urged use of CPT as official convoy system for local, state and federal powers.

The Delegation has recommended certain reports adopted by the AMA House to The MSMS Council for their review and possible action.

10. Interim Report of Committee on Planning and Priorities—Stuart M. Gould, Jr., MD, Chairman

This Committee promised in its progress report to The MSMS Council in April and to the spring meeting of the MSMS House of Delegates to offer some suggestions to the fall meeting of the MSMS House about possible changes in structure and committee work.

The Committee expresses its sincere appreciation to The MSMS Council for endorsing the proposals submitted in the spring, and to the House of Delegates for concurring with the changes advocated in the MSMS purposes, and for approving the lists of current objectives and intermediate longer-range objectives.

The Committee has met twice since the spring House and has had two working subcommittees.

This report is divided into three parts:

I. Committee History

II. Recommendations re Changes in Committee Work

III. Recommendations re Changes in Structure and Operations.

In making recommendations in Parts II and III, the Committee points out that if the House feels it cannot approve them, the House should refer the matter back to the Committee with comments and suggestions for further study. The Committee respectfully explains that the recommendations offer proposals that are in effect "packages" and therefore parts and pieces should not be rejected, amended, or approved.

The Committee is continuing its study of several other aspects of MSMS operation and will report again to the 1974 Spring House of Delegates.

I. COMMITTEE HISTORY

(Note: No action is required by the House of Delegates on this part of the report.)

The MSMS Planning and Priorities Committee was organized in January, 1972 to include broad geographic representation from the general membership, the House of Delegates, specialties, medical students, and so on. The Council suggested that there was a need to study priorities for MSMS activities and to consider the possible duplication of committee work.

The Alexander Grant Company analysis of the 1971 membership opinion survey was sent to members of the MSMS House of Delegates. The House of Delegates in the spring of 1972 decided the Planning and Priorities Committee also should consider the recommendations in the Grant report about member services, structure, etc.

A progress report to the 1972 fall meeting of the House of Delegates described in some detail the work of the Committee since the 1972 Spring Session. A subcommittee studied the opinion poll comments about membership services and our full committee adopted recommendations of a preliminary nature. These will be presented formally to the Spring Session in 1974.

The Committee has been enlarged since last fall. New members of the Committee are Dean Carron, MD, immediate past president of the Washtenaw County Medical Society; Homer Smathers, MD, immediate past president of the Wayne County Medical Society, and Frederick Sabin, MD, Marquette.

II. RECOMMENDATIONS RE CHANGES IN COMMITTEE WORK

Committee Recommendation to House of Delegates: That the House of Delegates approve the proposed changes in MSMS Committee work to establish Divisions, etc., and instruct the Committee on Constitution and Bylaws to prepare the necessary amendments for consideration by the 1974 Spring Session of the House. (The Committee also requests The MSMS Council to support the proposed changes and recommend that the House of Delegates take the action suggested above).

One of the major objectives of the Planning and Priorities Committee has been to try to streamline the MSMS committee structure to make a more viable arm of the Society to carry out the MSMS goals and programs.

Much discussion has been held on this subject. A special task force was appointed to consolidate ideas and to formulate them into a specific proposal for the Committee's consideration. The task force report was amended and approved. The recommendations follow this grouping.

A. Committee Organizational Chart

B. Basic Concepts of Proposed Committee Structure

C. Modus Operandi for Divisions/Committees/Task Forces

D. MSMS Purposes and Objectives Assigned to Divisions

E. MSMS Purposes and Objectives Assigned to Board of Directors

F. Administration Responsibilities

The proposed organizational chart for committee work follows on next page.

B—BASIC CONCEPTS OF THE PROPOSED COMMITTEE STRUCTURE

1. The Board of Directors shall have such operating committees as necessary to provide continuity and leadership.
2. MSMS objectives should be grouped into areas of common interest and Divisions should be established to coordinate and implement MSMS study and action to accomplish the goals.
3. Each Division should be led by a committee appointed by the Chairman of the Board of Directors with the concurrence of the Board.
4. Each Division would have Standing Committees and Ad Hoc Task Forces to study appropriate matters, to make recommendations to the Board of Directors, and to recommend possible changes in policy to the House through the Board of Directors. These Standing Committees and Ad Hoc Task Forces should be appointed by the Chairman of the Board with the concurrence of the Board. The Division Chairman will be invited to recommend members for appointment.
5. Each Division should include two or more members of the Board of Directors and five or more members of the MSMS House of Delegates. The chairman of the Division need not necessarily be a member of the Board of Directors.
6. The Division would meet at least twice a year, once to develop its action program to be submitted to the Board for approval, and later to monitor progress.
7. The Board of Directors may assign subjects for study to the Division Chairman and the appropriate Standing Committee or Task Force and request recommendations back to the Board. Task Forces and Standing Committees will report directly to the Board, with a copy to the Chairman of that Division for information.

C—MODUS OPERANDI FOR DIVISIONS/COMMITTEES/TASK FORCES

Divisions

The committee structure of MSMS shall consist of the following five Divisions:

Division 1—Legislation and Socio-Economics

Division 2—Medical Organization and Services to Members

Division 3—Communications and Public Service

Division 4—Health Care Delivery

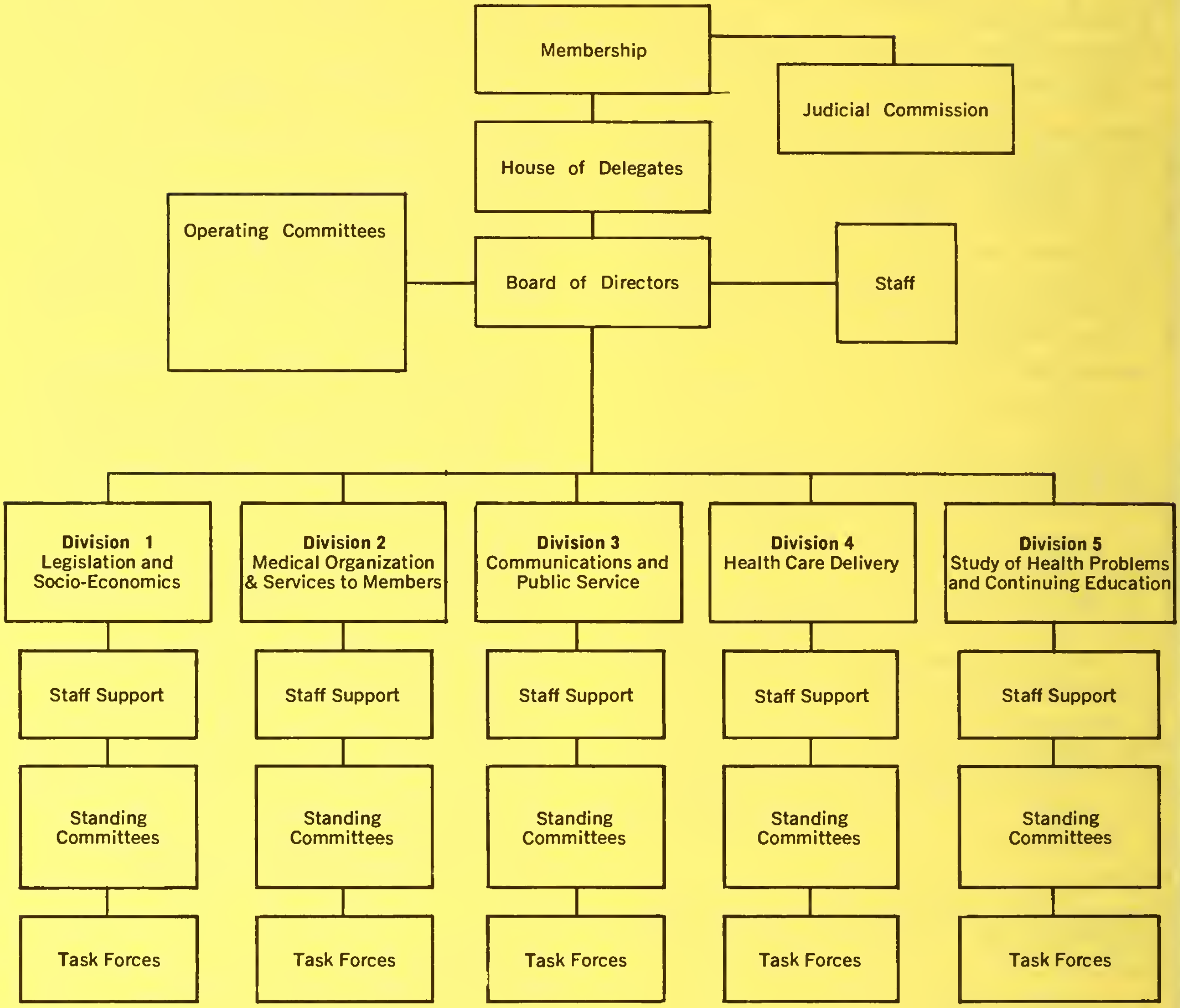
Division 5—Study of Health Problems and Continuing Education

Each Division Committee shall be composed of 10 to 30 members, appointed by the Chairman of the Board of Directors with the concurrence of the Board. Division members shall be appointed to serve three-year terms, with the terms staggered. No member may serve more than three terms. At least two members of the Board of Directors and at least five members of the House of Delegates shall serve on each Division Committee.

Each Division Committee shall meet twice a year. One meeting will be held for the purpose of developing its program for the year, with proposed budget, for presentation to the Board of Directors. In addition, each Division shall make recommendations to the Board of Directors regarding the Standing Committees and Task Forces it would like appointed to accomplish its goals. A second meeting of the Division will be held later to monitor progress.

Divisions are encouraged to initiate programs in addition to the assignments they receive from the House of Delegates and the Board of Directors. Divisions are requested to make recommendations to the appointing officer (the Chairman of the Board of Directors) concerning suitable members for their Standing Committees and Task Forces.

A—COMMITTEE ORGANIZATIONAL CHART


Membership
Judicial Commission
House of Delegates
Operating Committees
Board of Directors
Staff
Division 1 Legislation and Socio-Economics
Division 2 Medical Organization & Services to Members
Division 3 Communications and Public Service
Division 4 Health Care Delivery
Division 5 Study of Health Problems and Continuing Education
Staff Support
Standing Committees
Task Forces

Each Division shall be staffed by a Department of the Michigan State Medical Society.

Standing Committees

Under each Division will be Standing Committees to work in areas of major and/or ongoing concern.

Members of the Standing Committees shall be appointed by the Chairman of the Board of Directors with the concurrence of the Board.

Task Forces

Also under each Division shall be Task Forces which shall serve on an ad hoc basis on specific assignments.

Members of the Task Forces shall be appointed by the Chairman of the Board of Directors, with the concurrence of the Board.

DIVISION 1: LEGISLATION AND SOCIO-ECONOMICS

To Implement the following MSMS Purposes and Objectives:

To stimulate advancement of the . . . economic and medical political knowledge of its members in order that the doctor may better serve his patients and the public health generally.

To advocate fair remuneration for services rendered.

To seek solution to Medicaid problems.

To develop and support MSMS policies re current legislation.

To introduce legislative measures to alleviate professional liability insurance problems.

To conduct and evaluate MSMS sponsored practice management seminar on a pilot basis.

To explore and determine the proper MSMS role in matters of state and federal funding of medical and health services.

To initiate a more effective informal liaison with Michigan Medical Service.

(Note: Each division would have Standing Committees and Ad Hoc Task Forces)

DIVISION 2: MEDICAL ORGANIZATION AND SERVICES TO MEMBERS

To Implement the following MSMS Purposes and Objectives:

To constitute, support and advise the American Medical Association in cooperation with similar societies of other states, in meeting its appropriate responsibilities.

To charter and organize constituent component medical societies.

To encourage medical students and physicians-in-training to participate in organized medicine in order to enable MSMS to be representative of all physicians.

To institute and provide specific services to meet the needs of the members.

To increase assistance to components in membership retention and recruitment.

To develop program of member assistance.

To encourage and assist component medical societies so they can take active roles in community health related programs such as area-wide planning.

To conduct opinion surveys of MSMS membership on important issues.

(Note: Each division would have Standing Committees and Ad Hoc Task Forces)

DIVISION 3: COMMUNICATIONS AND PUBLIC SERVICE

To Implement the following MSMS Purposes and Objectives:

To conceive, develop and administer health education programs designed to improve public understanding, awareness and acceptance of good medical standards, practices and concepts, as they relate to personal health, scientific progress and society's advancement.

To provide medical leadership in meeting the health needs of the people by working with other medical and non-medical groups and individuals.

To enhance physician-patient relationships, as basic to the delivery of quality health care.

To ensure the adequacy of medical manpower by attracting capable people into the medical and health professions and to work toward the most effective distribution of their services.

To support efforts of those who would enhance the reputation and services of the medical profession.

To carry forward the five present MSMS public relations projects, which are VD Education, Education about the Medical Aspects of Pollution, Chiropractic Education, Work to Make Medical Assistants More Effective Communicators, and Help People Find a Doctor, and to especially concentrate on projects to educate both the physician and the public about chiropractic.

To continue to improve techniques and methods of communicating with the members and the public; and to encourage communication from the members to MSMS.

(Note: Each division would have Standing Committees and Ad Hoc Task Forces)

DIVISION 4: HEALTH CARE DELIVERY

To Implement the following MSMS Purposes and Objectives:

To promote quality medical and health care by development and support of activities appropriate to this goal.

To ensure the adequacy of medical manpower by attracting capable people into the medical and health professions and to work toward the most effective distribution of their services.

To monitor and coordinate development of PSROs in Michigan.

To create medical care guidelines for adoption by regional PSROs.

To study the trends of utilization of emergency rooms and recommend appropriate MSMS involvement.

To develop concepts and models of ambulatory care systems so physicians can provide leadership in this matter.

To begin efforts to involve MSMS in MD Placement Activities.

To encourage and assist component medical societies so they can take active roles in community health related programs such as area-wide planning.

(Note: Each division would have Standing Committees and Ad Hoc Task Forces)

DIVISION 5: STUDY OF HEALTH PROBLEMS AND CONTINUING EDUCATION

To Implement the following MSMS Purposes and Objectives:

To stimulate advancement of the science and art of medicine and continually to seek to advance the medical, scientific, social, environment . . . knowledge of its members in order that the doctor may better serve his patients and the public health generally.

To promote quality medical and health care by development and support of activities appropriate to this goal.

To foster and support continuing medical education.

To develop continuing medical education certification plan for Michigan.

(Note: Each division would have Standing Committees and Ad Hoc Task Forces)

E—MSMS PURPOSES AND OBJECTIVES ASSIGNED TO BOARD OF DIRECTORS

The following MSMS Purposes and Objectives are to be assigned to the Board of Directors:

To constitute, support and advise the AMA in cooperation with similar societies of other states.

To charter and organize constituent component medical societies.

To ensure the adequacy of medical manpower by attracting capable people into the medical health professions and to work toward the most effective distribution of their services.

To support the efforts of those who would enhance the reputation and services of the medical profession.

To continue current efforts of MSMS officers, Directors (Councilors) and staff members to visit each component medical society.

To continue new efforts to improve and increase MSMS working relationships with the medical specialty societies and the Council of Specialty Societies.

To conduct and evaluate MSMS sponsored practice management seminar on a pilot basis.

To coordinate and enlarge the negotiating activities in the broadest sense.

To encourage and assist component medical societies so they can take active roles in community health related programs such as area-wide planning.

(Note: The Board of Directors shall have such operating committees as necessary to provide continuity and leadership.)

F—ADMINISTRATION RESPONSIBILITIES

Following are some of the responsibilities of the MSMS staff:

—Development and continuous monitoring of budget
—Recruitment of new members and member retention
—Staffing of AMA Delegation
—Service to MSMS officers and directors
—Staffing of Judicial Commission
—Service to components
—Conduct socio-economic research
—Leadership development
—Service to specialty societies
—Publication of *Michigan Medicine* and other publications
—Implementation of MSMS legislative program
—Liaison with allied professions
—Liaison with governmental agencies (state and federal)
—Coordination and staffing of Annual Session, House of Delegates, and other conferences, seminars, and meetings
—Coordination and support of MSMS Divisions, Permanent Committees, and Task Forces
—Maintenance of all MSMS records, including financial and membership
—Dues collection
—Providing informational service to the public
—Supervision of MSMS personnel
—Conducting surveys
—Maintaining building and property
—Reproduction of information for distribution to members, etc.

III. RECOMMENDATIONS RE CHANGES IN STRUCTURE AND OPERATIONS

Committee Recommendation to the House of Delegates: That the House of Delegates approve the following changes in Structure and Operation and instruct the Committee on Constitutional and Bylaws to prepare the necessary amendments for consideration by the 1974 spring session of the House.

(The Committee also requests The MSMS Council to support the proposed changes and to recommend that the House of Delegates concur with the suggestions that follow).

Committee members are sincerely interested in making the overall medical society more effective to serve both the profession and the public. Members are agreed that changes should not be proposed merely for the sake of change.

Committee members agree that some changes would be wise, but that these should be evolutionary in nature rather than revolutionary.

The impetus to systematically study the need for change was taken by the House of Delegates in 1971 when it approved a Council recommendation that the attitudes of physicians be surveyed by an outside consultant group. The report in 1972 of the Alexander Grant Company, of Detroit, made some recommendations based on the company's interpretation of attitudes expressed by members in the survey.

The Committee weighed the pros and cons of the ideas offered by the Grant report and decided to develop some alternative exercises on organizational structure to give the Committee more options to consider. Four detailed approaches have been studied.

The four exercises and elements contained therein were discussed at every meeting of the Committee and by committee members with associates across the state. Questions were asked about how members would like to change the election methods, whether they wanted to continue the House of Delegates, etc., etc.

The Committee at two meetings this summer reached agreement on some new concepts and then developed a set of changes that would provide for these new principles.

The suggestions being advanced by the Committee would change the structure and operation of MSMS in the following ways:

1. Would provide every MSMS member with the opportunity to cast his vote for MSMS president-elect, secretary and treasurer.
2. Would provide every MSMS member with the opportunity to vote for the doctor(s) who would represent his geographic district of the state on the MSMS Board of Directors, and in the AMA House of Delegates.
3. Would increase the size of the MSMS Board of Directors to provide for better one-man one-vote representation.
4. Would provide for five public appointees to serve on MSMS Board of Directors.
5. Would modify the present procedures for the election by the MSMS House of Delegates of the MSMS delegates and alternates to the AMA House of Delegates.

The Committee offers the following comments and recommendations re the component societies, MSMS officers, etc.

Component Societies

1. No specific amendments are proposed to make any changes mandatory re the present component medical societies. The Committee does respectfully recommend that each component society examine its size and operation toward maximizing the opportunities for each member to participate effectively in the operations of the component society. The smaller component societies are encouraged to consider possible advantages in joining with adjacent components in order to have more effective scientific meetings, in order to strengthen programs in legislation, etc.

MSMS House of Delegates

1. The House of Delegates should continue as the policy-making body. The present provisions for representation from the component societies should be continued. The present provisions for the sections to elect delegates should be continued.
2. The House of Delegates shall not have study committees, but matters requiring further study should be referred to the MSMS Board of Directors, and the Board should be requested to report back to the House.
3. The House should establish 10 consecutive years of service as the maximum tenure for delegates. Delegates may be seated again after a break of at least one year.
4. The House of Delegates shall continue to elect its own Speaker and Vice-Speaker.

MSMS Officers

1. The President-Elect shall be elected by mail vote of the membership. The MSMS Nominating Committee shall consist of two members of the House appointed by the Speaker, two members of the Board of Directors named by the presiding officer, and two members at large appointed by

the MSMS President. The component medical societies shall be asked to submit suggestions. This nominating committee shall submit the names of at least two physicians for the office of president-elect. A candidate also may be nominated by petition containing the names of at least 200 MSMS members including at least 25 from at least 13 regions. The permission of each candidate must be obtained before the ballot is mailed. Three physicians shall be appointed by the presiding officer of the Board to serve as tellers. Election shall be by plurality.

2. The Secretary shall be elected by vote of the membership, following the same procedure as described for the president-elect. The secretary shall be eligible for re-election.

3. The Treasurer shall be elected by vote of the membership, following the same procedure as described for the president-elect. The treasurer shall be eligible for re-election.

4. The current procedure of appointment by The Council of an assistant secretary and an assistant treasurer shall be continued by the Board.

5. The Board of Directors shall elect its own Chairman and Vice Chairman (as The Council does now).

MSMS Board of Directors:

1. The present Council shall be called the MSMS Board of Directors, which is an assurate description of the role fulfilled by this body now.

2. New boundary lines shall be established for MSMS Regions in order to capitalize on changing patterns of medical referrals and in order to establish better geographic medical communities with common interest. The wording "MSMS Region" shall replace the former "Councilor District." The one-man-one-vote principle shall apply generally in regards to the number of directors to be elected from each Region depending upon the number of MSMS members in each Region.

Map A shows present Councilor district boundaries. Map B shows proposed new boundaries for Board of Directors regions. (See pages 892 & 893)

3. Election of members of the Board of Directors shall be by vote of the membership from each Region. A Nominating Committee (described also under the heading "MSMS Officers") shall consist of two members of the House appointed by the Speaker, two members of the Board of Directors named by the presiding officer, and two members at large appointed by the MSMS President, Component medical societies shall be invited to submit recommendations. The nominating committee shall submit the names of at least two physicians from the Region for each Board position for that Region. A candidate also may be nominated by petition of at least *15%* names of members from that Region. Three physicians shall be appointed by the presiding officer of the Board to serve as tellers. Election shall be by plurality.

4. The terms of Board Members from the Regions shall be for 3 years not to exceed three terms. The terms shall be staggered, with one third of the total elected each year.

5. The Board of Directors shall meet quarterly, or upon call of the Chairman if deemed necessary.

6. The Board of Directors shall be composed of:

A. President
B. President-Elect
C. Secretary
D. Treasurer
E. Speaker of the House of Delegates
F. Chairman of the MSMS Delegation to the AMA House
G. Immediate Past President
H. The Directors from each of the Regions
I. 5 non-MD public members elected by the Board to serve terms of 3 years and not more than 3 consecutive terms

7. The Board shall establish an Operating Committee to meet each month or when deemed necessary to implement decisions of the Board and to direct the work of the MSMS staff. The Operating Committee shall be comprised of:

A. Chairman of the Board of Directors, who shall serve as chairman
B. President
C. President-Elect
D. Secretary
E. Chairman of the Finance Committee
F. Three Regional Directors, elected by the Board
G. Speaker of the House of Delegates

8. The Board shall encourage members, delegates, component societies, specialty societies, etc., to submit resolutions to the MSMS Board of Directors at any time, with the Board taking action when appropriate or recommending policy positions to the House when necessary.

MSMS Delegates to the AMA:

1. The election of the delegates and alternates to the AMA House of Delegates shall continue to be by the MSMS House of Delegates.

2. All MSMS delegates to the AMA shall be elected in even-numbered years for two-year terms, as specified by the AMA, and shall take office immediately after election. (In effect, MSMS would immediately notify the AMA of the election of delegates and alternates for terms that officially began Jan. 1 of that year.) They shall serve until their respective successors shall have been elected.

3. All MSMS alternate delegates shall be elected in odd-numbered years for two-year terms, to take office immediately after election. Alternate delegates shall have relative seniority according to the respective number of votes received, and such seniority shall be designated at the time of the election. They shall serve until their respective successors shall have been elected.

(Note: Some special procedures will be needed to implement this new election procedure because MSMS now elects half of its delegates and half of its alternates each year. Perhaps half the delegates and alternates would have to be elected under the old or new way for one-year terms in order to get the entire new procedure in motion.)

4. To help assure the one-man-vote principle, the state of Michigan shall be divided into three geographic areas for the election of the MSMS delegates and alternates to the AMA House of Delegates. Each area would elect two delegates and two alternates. The state shall be divided as follows: (See Map C)

Area AA shall include Wayne County.

Area BB shall include the counties of Berrien, Cass, St. Joseph, Branch, Hillsdale, Lenawee, Monroe, Van Buren, Kalamazoo, Calhoun, Jackson, Washtenaw, Allegan, Eaton, Ingham, Livingston, Oakland, Macomb, Clinton, Gratiot.

Area CC shall include the counties of Ottawa, Kent, Barry, Ionia, Shiawassee, Genesee, Lapeer, St. Clair, Muskegon, Montcalm, Saginaw, Tuscola, Sanilac, Huron, Oceana, Newaygo, Mecosta, Isabella, Midland, Bay, Mason, Lake, Oscola, Clare, Gladwin, Arenac, Manistee, Wexford Missaukee, Roscommon, Ogemaw, Iosco, Benzie, Grand Traverse, Kalkaska, Crawford, Oscoda, Alcona, Leelanau, Antrim, Otsego, Montmorency, Alpena, Charlevoix, Emmet, Cheboygan, Presque Isle, Gogebic, Ontonagon, Houghton, Keewenaw, Baraga, Iron, Dickinson, Marquette, Menominee, Alger, Delta, Schoolcraft, Luce, Mackinac, Chippewa.

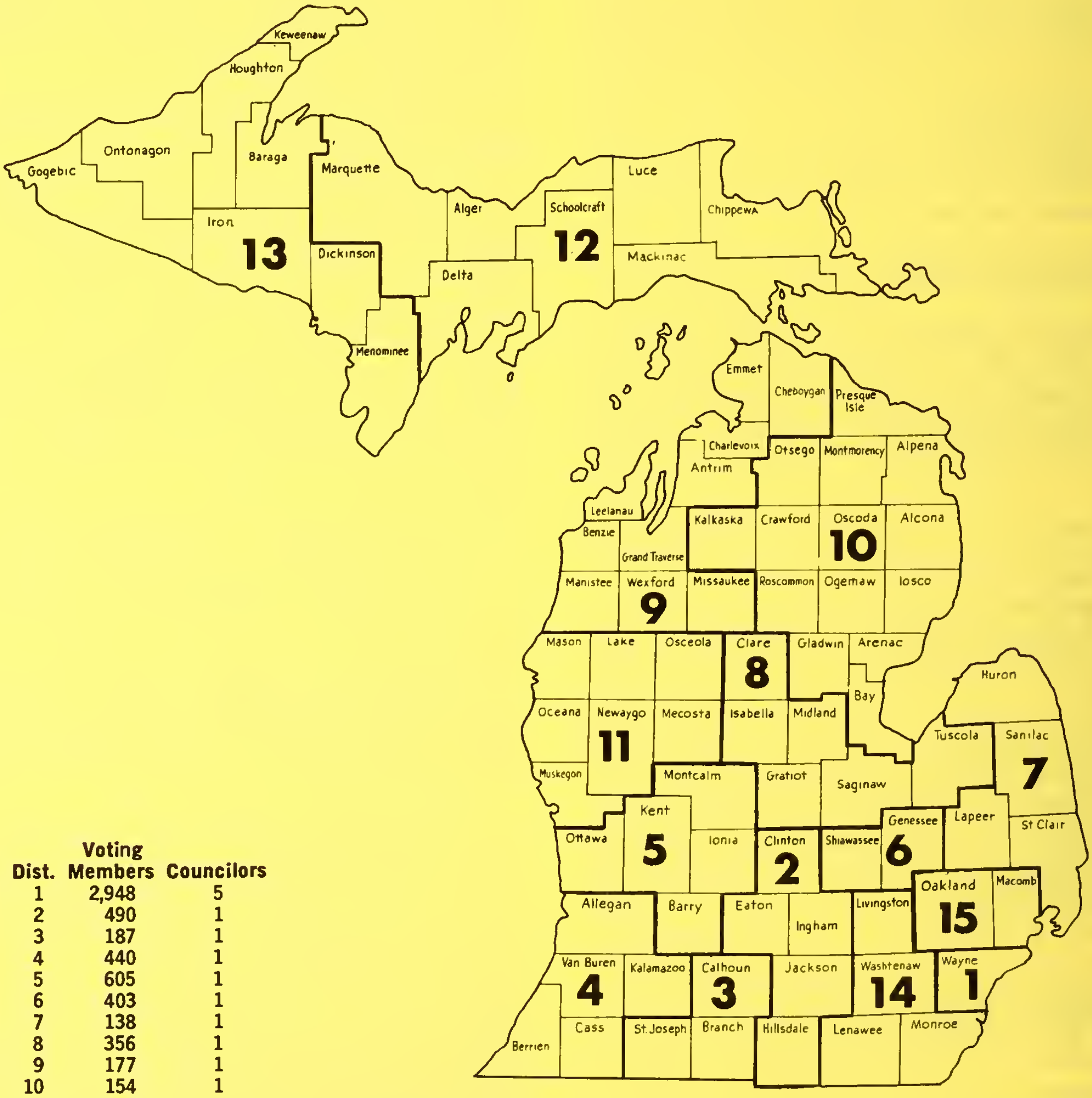
The delegates from component societies shall vote *only* for nominees from their area for the area positions. (For example, the delegates of Wayne County would vote only for nominees to represent Area AA.) Delegates of the MSMS Sections shall vote in the area which includes their component society. Delegates from the three SAMA chapters shall vote in the area which includes their medical school.

5. To continue to some degree the present MSMS at-large elections of AMA delegates and alternates, all the delegates will vote for two delegates and two alternates.

6. The MSMS Nominating Committee (described elsewhere) with the addition of the chairman of the AMA

MAP A

Present boundary lines for Councilor Districts, numerical strength in each, and number of Councilors serving from each:

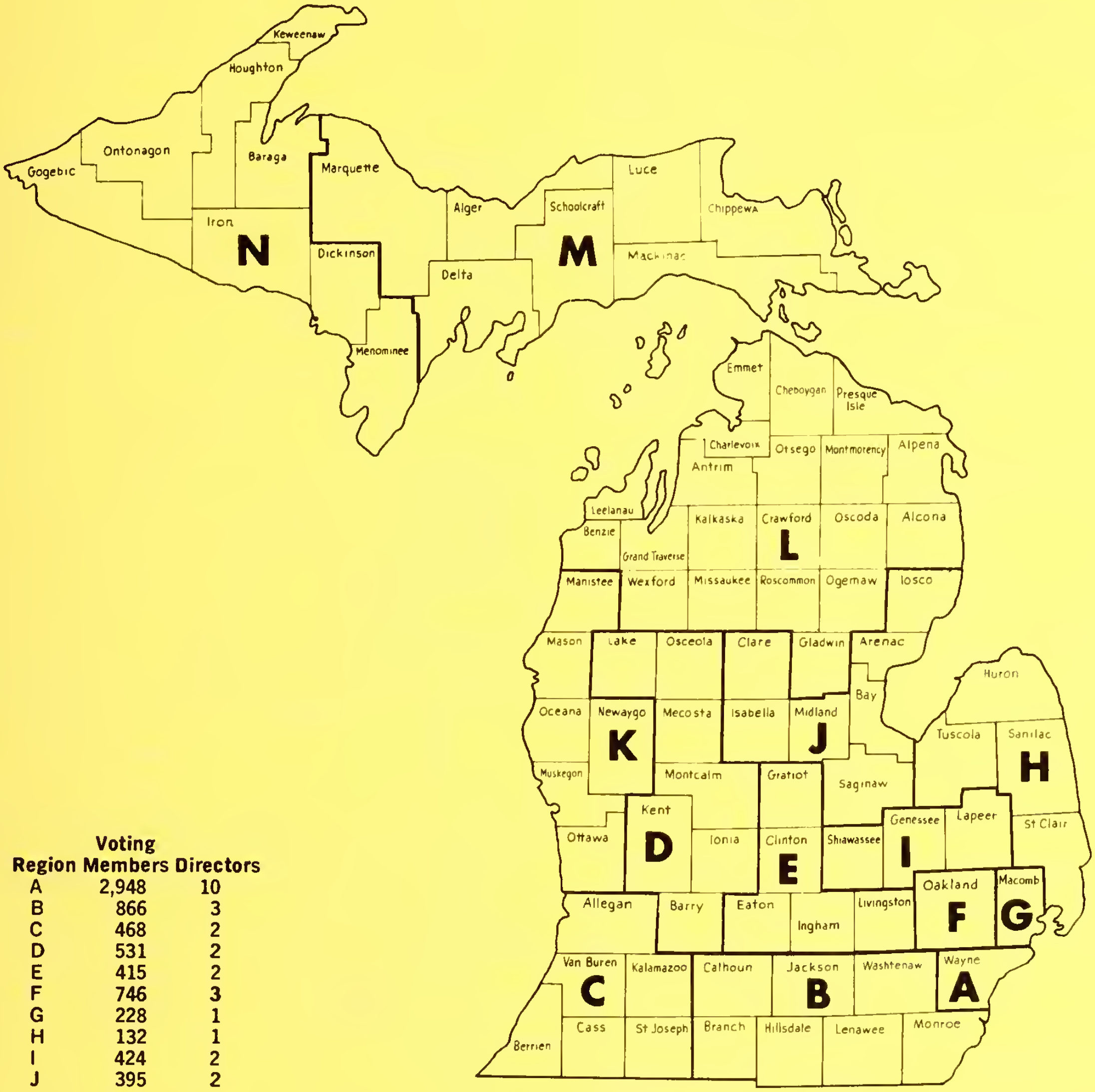

Keweenaw
Houghton
Ontonagon
Gogebic
Baraga
Marquette
Iron
13
Dickinson
Menominee
Alger
Delta
Schoolcraft
12
Luce
Chippewa
Mackinac
Emmet
Cheboygan
Presque Isle
Charlevoix
Antrim
Otsego
Montmorency
Alpena
Leelanau
Benzie
Grand Traverse
Kalkaska
Crawford
Oscoda
10
Alcona
Manistee
Wexford
9
Missaukee
Roscommon
Ogemaw
Iosco
Mason
Lake
Osceola
Clare
8
Gladwin
Arenac
Bay
Huron
Oceana
Newaygo
11
Mecosta
Isabella
Midland
Tuscola
Sanilac
7
Muskegon
Montcalm
Gratiot
Saginaw
Kent
5
Ottawa
Ionia
Clinton
2
Shiawassee
Genessee
6
Lapeer
St Clair
Oakland
15
Macomb
Allegan
Barry
Eaton
Ingham
Livingston
Van Buren
4
Kalamazoo
Calhoun
3
Jackson
Washtenaw
14
Wayne
1
Berrien
Cass
St. Joseph
Branch
Hillsdale
Lenawee
Monroe

Dist.	Voting Members	Councilors
1	2,948	5
2	490	1
3	187	1
4	440	1
5	605	1
6	403	1
7	138	1
8	356	1
9	177	1
10	154	1
11	183	1
12	117	1
13	74	1
14	593	1
15	974	2
		20

NOTE: One Councilor now represents as many as 605 voting members in District #1 or as few as 74 in District #13.

MAP B

Suggested modifications in boundary lines for new MSMS Regions, numerical strength in each, and number of members to be elected in each to the MSMS Board of Directors.

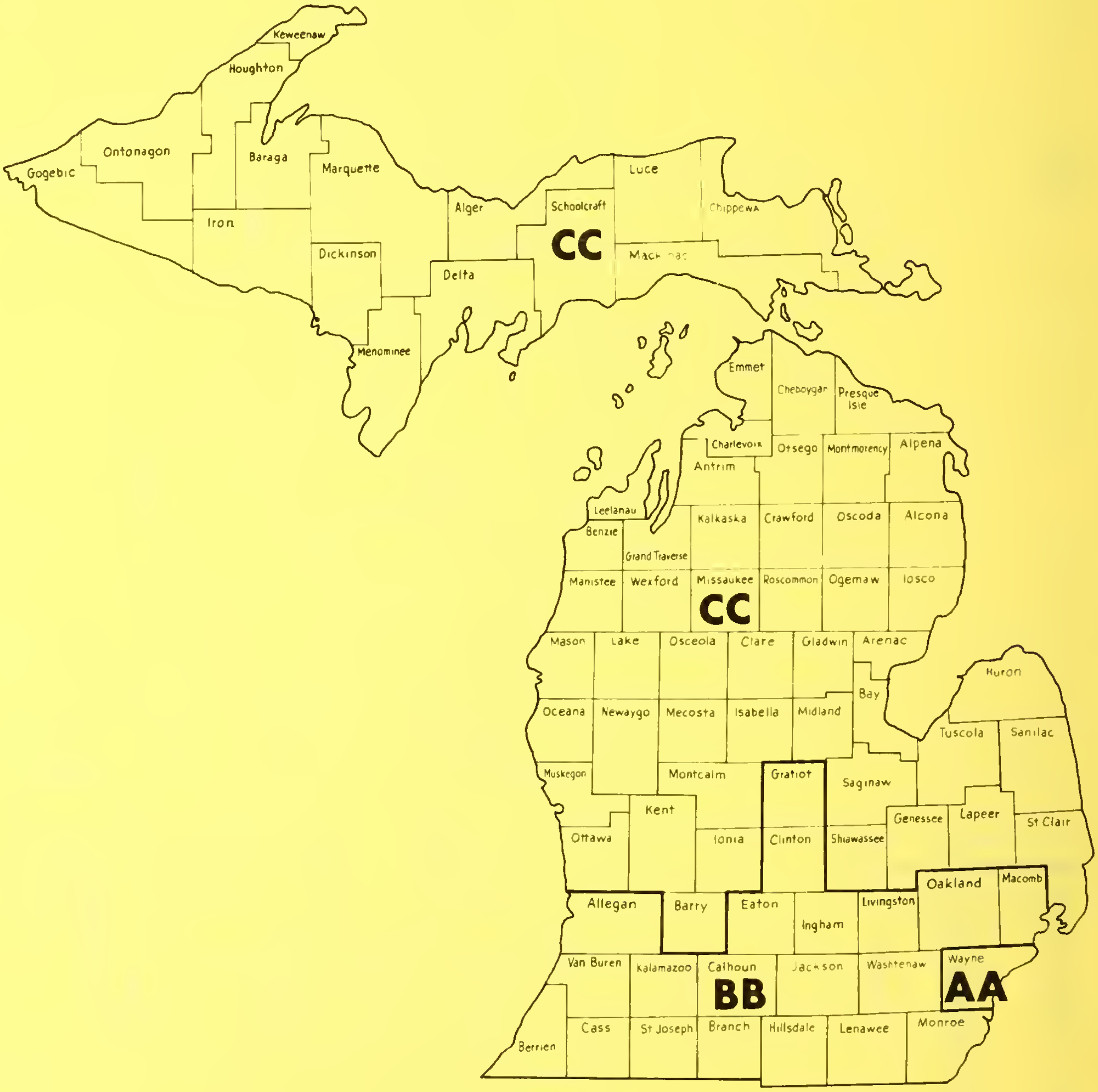

Keweenaw
Houghton
Ontonagon
Gogebic
Baraga
Marquette
Iron
N
Dickinson
Menominee
Alger
Delta
Schoolcraft
M
Luce
Chippewa
Mackinac
Emmet
Cheboygan
Presque Isle
Charlevoix
Antrim
Otsego
Montmorency
Alpena
Leelanau
Benzie
Grand Traverse
Kalkaska
Crawford
Oscoda
Alcona
L
Manistee
Wexford
Missaukee
Roscommon
Ogemaw
Iosco
Mason
Lake
Osceola
Clare
Gladwin
Arenac
Oceana
Newaygo
Mecosta
Isabella
Midland
Bay
Huron
K
J
Tuscola
Sanilac
H
Muskegon
Montcalm
Gratiot
Saginaw
Kent
Genessee
Lapeer
St Clair
Ottawa
D
Ionia
Clinton
Shiawassee
I
E
Oakland
Macomb
Allegan
Barry
Eaton
Ingham
Livingston
F
G
Van Buren
Kalamazoo
Calhoun
Jackson
Washtenaw
Wayne
C
B
A
Cass
St Joseph
Branch
Hillsdale
Lenawee
Monroe
Berrien

Region	Voting Members	Directors
A	2,948	10
B	866	3
C	468	2
D	531	2
E	415	2
F	746	3
G	228	1
H	132	1
I	424	2
J	395	2
K	271	1
L	224	1
M	117	1
N	74	1
		32

Predicated on basis of one director per every 225-275 voting members. Exceptions are the Upper Peninsula and the thumb area.

MAP C

Proposed division of state into three areas for the election by the House of Delegates of MSMS delegates to the AMA House of Delegates.


Keweenaw
Houghton
Ontonagon
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Marquette
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Dickinson
Menominee
Alger
Delta
Schoolcraft
Luce
Chippewa
Mackinac
CC
Emmet
Cheboygan
Presque Isle
Charlevoix
Antrim
Otsego
Montmorency
Alpena
Leelanau
Benzie
Grand Traverse
Kalkaska
Crawford
Oscoda
Alcona
Manistee
Wexford
Missaukee
Roscommon
Ogemaw
Iosco
CC
Mason
Lake
Osceola
Clare
Gladwin
Arenac
Huron
Bay
Oceana
Newaygo
Mecosta
Isabella
Midland
Tuscola
Sanilac
Muskegon
Montcalm
Gratiot
Saginaw
Kent
Genessee
Lapeer
St Clair
Ottawa
Ionia
Clinton
Shiawassee
Oakland
Macomb
Allegan
Barry
Eaton
Ingham
Livingston
Van Buren
Kalamazoo
Calhoun
Jackson
Washtenaw
Wayne
BB
AA
Berrien
Cass
St Joseph
Branch
Hillsdale
Lenawee
Monroe

Area	Regions Included	Voting Members
AA	A	2,948
BB	B,C,E,F,G	2,723
CC	D,H,I,J,K L,M,N	2,168

delegation, shall submit the names of at least two physicians from Area AA for each position, at least two physicians from Area BB for each position, and at least two physicians from Area CC for each position; and at least two physicians from Michigan for each of the at-large positions.

7. Whenever any delegate is unable to attend an AMA House meeting, the alternate delegate who received the highest number of votes from that area shall be seated. For example, when a delegate from the AA area cannot attend, the alternate who led the AA area race for alternate shall move up. When an at-large delegate cannot attend, the alternate who had the largest number of votes shall be seated. If the alternate who had the highest number of votes is unable to serve, the second alternate from that area shall be seated. If neither area alternate is able to serve, then the chairman of the MSMS delegation to the AMA shall designate a delegate from the entire pool of alternates for that meeting only.

8. The members of the delegation would continue to elect its own chairman and vice chairman.

REFERENCE COMMITTEE D, Lewis E. Simoni, MD, Chairman, recommended the interim report of the Planning and Priorities Committee be disseminated to the component medical societies for review and discussion. Further, that each society develop suggestions and return these to the Planning and Priorities Committee by Feb. 1, 1974, for consideration prior to their report to the Spring Annual Session.

THE HOUSE adopted the report of the Reference Committee.

11. Report of the Woman's Auxiliary—Mrs. Fleming Barbour, President

(Presented in written form.)

With the 50th Anniversary celebration of the Woman's Auxiliary to AMA, Michigan participated in the program by selecting as its theme . . . "Building for the Future on the Heritage of the Past." Throughout the year, the idea of continuous "Building for the Future . . ." was stressed by urging active participation in all auxiliary programs.

Our Michigan State Auxiliary was restructured to conform to changes at the national level and an individual membership chairman was appointed. Although our membership did not grow as we hoped, even though given No. 1 priority . . . the following figures we present:

Total State Members	3,212
Total National Members	3,152

No. 2 priority for the year was the concentration on our six auxiliaries in the Upper Peninsula to help to make them feel a definite part of our Michigan State Organization. We were more than delighted when two District Directors from the UP flew to the January Board Meeting in Lansing; also when three members attended our Spring Conference at the half-way location, Hidden Valley at Gaylord, . . . half-way between Detroit and Marquette. . . two distant points!

Contributions to AMA-ERF totaled $40,169.92 which gave us a per member participation of $12.89 on a statewide basis. For this we received National recognition.

Under International Health, the continual concern of the members has related in the form of numerous contributions of pharmaceuticals and donations for medical care. Members have participated in Project Concern. Physicians and wives have volunteered to serve in health fields in Nigeria, Ethiopia, Iran, Niger Republic of Africa, Haiti, and Dominican Republic. At least one member is participating in the SKIP program.

Legislative Day in Lansing was attended by 147 members, Senators and Representatives. The LEGS program is in motion in at least five auxiliaries and since Legislative Day, it has taken on momentum. The interest stimulated is gratifying.

Through National's suggestion, FIND and the ALLIED HEALTH EDUCATION DIRECTORIES have been distributed in many of the High Schools and Junior High Schools throughout the state, as well as gift subscriptions of TODAY'S HEALTH which have found their way in the most remote of places . . . a public relations service.

Meal Services for the Aging and Homebound as well as the ever popular Loan Closet (equipment for the bedridden and aged) are two major contributions of this year. On the other side of the age scale, Children and Youth have received gifts of "Hello Hospital" (co-authored by a Michigan State Medical Auxiliary member) by being given to the various libraries, as gifts of the auxiliaries. Drug Centers and clinics have been set up and manned by our auxiliary members. Another group has just completed a Directory of Services and Information in the field of Mental Health and has taken charge of its distribution.

Our "5 Point Telstar Program for Michigan," TEL-A-PHONE REASSURANCE, TEL-E-VISION, TEL-A-PARENT, TEL-A-NEWCOMER, TEL-AN-INTERN, promoted as a Service Project stimulated enough interest so that each point of the star was elongated and grew, due to the active participation of many auxiliaries.

The Michigan State Medical Auxiliary has been represented at the Department of Education, State of Michigan, having to do with nutrition in the form of school lunches. Big strides are being taken even though we are still in the discussion stages.

Our Health Careers Chairman serves as a delegate to the Michigan Health Council. We are represented on the MSMS Legal Affairs Committee by our Legislative Chairman. Two members serve in an advisory capacity to the MSMS Committee on Public Relations.

"Building for the Future on the Heritage of the Past" has made this year an especially rewarding and meaningful year for the membership as well as your State President.

12. Report of the American Association of Medical Assistants, State of Michigan—Mrs. Audrie Chute, CMA, President

(Presented in written form.)

In this annual report to the House of Delegates, members of the American Association of Medical Assistants, State of Michigan express their appreciation for the support and encouragement of the doctors of Michigan; Mr. Warren Tryloff, MSMS Executive Director; Mr. Herb Auer, Director of Communications, MSMS; and the invaluable help of Mrs. Jackie Van Deventer, MSMS Women's Coordinator.

AAMA, the only medical assistants organization to have merited official commendation by the AMA, is a professional association of medical assistants, secretaries, nurses, technicians, and office administrators.

Highlights of our activities this year include our educational seminars held in July at the Grand Hotel, Mackinac Island, and scheduled for September, 1973, in Kalamazoo and January, 1974, in Port Huron. Other opportunities for professional improvement are the annual convention—to be held at the Detroit Hilton, Detroit on April 25-28, 1974, monthly meetings, study groups, lectures, continuing education programs, and certification.

The AMA-AAMA has established a certifying board similar to that of the medical specialty boards. Medical assistants who demonstrate a high level of competency by passing the exams may achieve certification in clinical, administrative work, or both. Michigan now has 23 Certified Medical Assistants (CMA).

When our House of Delegates convenes at the national convention in Washington, D.C., October, 1973, Michigan will proudly present Betty Lou Willey, CMA, Port Huron, as the first candidate from Michigan for the office of President-Elect of the AAMA. Pride in the promotion of our candidate is shared with MSMS. Dorothy Brandis, Lansing, a past state president, is our candidate for AAMA Trustee. Delegates to the AAMA Convention from Michigan are Betty Boers, Vice Speaker of the House; Audrie Chute, CMA, President; Donna Fogal, Speaker of the House; Clair Van Dam, President-Elect; and as Alternate Delegates, Dorothy Brandis and Margaret Broadwell, Immediate Past President.

We are grateful for the guidance, interest, and service of our medical advisors. Appointed by The Council of MSMS to serve this year are: Paul T. Lahti, MD, Chairman; John J. Coury, MD; Albert D. Engstrom, MD; David W. Hills, MD; J. H. Hoffman, MD, and Laszlo Kovacsi, MD.

Medical assisting in the office is the largest allied health field excluding nurses. In a recent survey by AAMA of its members, the results showed:

7% were LPN, 10% were RN, 18% were CMA, 29% had taken some form of medical assisting course, 5% were X-ray technicians, 66% had taken laboratory technical courses, 19% other medical or allied education.

Doctors, encourage your medical assistants to take the first step toward self-improvement and better job performance by joining AAMA.

Reports of the Council

13. Remarks of The Council Chairman—Robert M. Leitch, MD

The printed Annual Report of The Council was sent to you last week for review. This records in organized fashion the actions and deliberations of The Council during 1973. You have seen the detail of each of The Council's meetings, for the minutes are mailed to you following each meeting.

So today I want to bring you up to date on the happenings and Council actions since the Midsummer Session of The Council in August.

We met in September and again this morning.

First, I want to report that The Council concurs in the Speaker's decision that the House will implement the changeover from a Fall Annual Session to a Spring Annual Session simply by extending the terms of all officers and Councilors for six months, on a one-time basis.

The Council has had periodic progress reports from the Committee on Planning and Priorities, the most recent in September. We received that report concurrently with the mailing to members of the House of Delegates. This Committee has truly worked hard to carry out its responsibilities and the charge from this House to review the committee structure of MSMS and its organization. But, even though The Council has received progress reports, at our last meeting we concluded that the Committee's recommendations were so complicated and so important that they deserved more deliberate consideration than we were able to give them in a single meeting of The Council. Therefore we have decided to assign the review of the recommendations to a subcommittee which in turn will report its recommendations to The Council. These then will be evaluated and returned to the Planning and Priorities Committee. Similarly, The Council adopted a motion urging the House of Delegates to avoid hasty action on the report—to study it, make comments and suggestions and delay any final action until the Spring 1974 meeting of the House.

Since the printed report of The Council was written, the Medicaid Liaison Committee has met with counterparts from the Department of Social Services and reported to The Council at its last meeting. The Council appreciates the fine work of this committee and commends its chairman, James Fryfogle, MD.

The supervision of the finances of MSMS is an important responsibility. This responsibility is handled by the Finance Committee of The Council, chaired by Ernest P. Griffin, Jr., MD, of Flint. A balance sheet is provided in the Annual Report of The Council and, as you recall, the MSMS audit for the previous fiscal year is reviewed by the Ways and Means Committee at the spring meeting of the House of Delegates.

Doctor Griffin and Treasurer John Ylvisaker of Pontiac will meet tomorrow with the Ways and Means Committee to update Doctor Dave Siegel and his committee and to answer any questions they might have at this time about the present and future state of our finances. Doctor Ylvisaker as Treasurer has some additional comments regarding the MSMS financial picture, and I would like to call upon him now for those words.

Doctor Ylvisaker: My report to the spring meeting of the House of Delegates gave a review of our system of financial operation, summarized our investment program, and provided the Ways and Means Committee with a review of the 1972 audit. My fall report deals with the current status of our budget, provides comments on our funds and outlines income and expense estimates for 1974 and 1975.

MSMS currently is operating well within budget. We will achieve an estimated $45,000 overage of income over expenses at fiscal year-end on November 30, 1973, by virtue of an increase of dues income and interest income and a number of savings in scattered budget items. Our operational funds are now adequate to bridge the usual hiatus period from fiscal year-end until dues receipts materialize beginning in January and February.

The capital funds are performing much in accordance with the market. We have benefited by higher interest rates but experienced minimal decreases in market value in line with the Dow as recorded in our last official report at August 31. However, the recent market rise has materially improved our position again, as one might anticipate.

Some preliminary estimates for the 1974 budget have been carefully prepared by the budget committee for review by the Finance Committee in November. Based upon current information and budget projections, a relatively small budget deficit will be encountered. This deficit can be covered by the 1973 surplus without need for a dues increase. However, with continued cost increases and needs for expansion as our Society grows, it is apparent that a dues increase for 1975 will be a strong possibility.

Thank you, Doctor Ylvisaker.

The Bureau of Economic Information has made some important contributions this year which are detailed in The Council's report, and I urge you to particularly review this section of that report.

MSMS is attempting to increase its services to component medical societies and on August 4 authorized the staff to offer dues collection service to component societies on a voluntary basis this year, and to present a proposal next year for computerizing a dues collection system for MSMS and component societies.

In our continuing efforts to seek solutions to the paper work problems in physicians' offices, The Council this morning authorized MSMS to seek to have introduced in the State Legislature a proposal mandating the State Insurance Commissioner to promulgate a uniform health insurance claim form for use by all health insurance companies doing business in Michigan, and all state agencies which require claim forms. This idea was originated by our colleague—the Oregon Medical Association—and was enacted into legislation in Oregon only recently.

Your leadership has been increasingly effective, I believe, in determining what decisions need to be made and in implementing those decisions once they are made. Staff support for The Council and committees, providing the information and background necessary to make sound decisions, has been even more effective this year as the new officers and committee chairmen learn to make the most efficient use of our able staff members.

I believe there is a consensus in The Council, indeed a consensus in this House, that near-term objectives must be identified so that the leadership and staff can address themselves to the highest priority objectives of the Society. A tangible outgrowth of this House of Delegates session ought to be the expression of these high priority concerns. I can assure you that The Council, as one of its first orders of business in November, will begin the identification of near-term objectives so that our manpower and financial resources will be brought to bear on those things that you want done first.

According to the Bylaws, The Council must nominate to the House candidates for certain offices. Here are The Council's nominations, which I have transmitted to the Speaker:

Secretary:	Kenneth H. Johnson, MD, Lansing
Assistant Secretary:	David Siegel, MD, Lansing
Treasurer:	John R. Ylvisaker, MD, Pontiac
Assistant Treasurer:	Ernest P. Griffin, Jr., MD, Flint

The staff has been maintained at its present size for several years. We are constantly reassessing whether we require more or fewer staff members, depending upon our specific requirements. The possibility exists, as I am sure you are aware, that in the near future we may need extra staff to support the efforts that this House specifies. The Council is alert to the possible need for enlarging our government relations staff as responsibilities grow, both in legislative liaison and interaction with state agencies that make rules and regulations.

It has been a real pleasure and honor to have served as the Chairman of The Council this past year. I've enjoyed the opportunity to work with your officers and staff in behalf of the Society.

14. Report of Council Activities

These pages report the highlights of The Council's work during the past year in the ongoing areas of Michigan State Medical Society service.

Detailed reports are not necessary since minutes of The Council are mailed regularly to delegates and component medical societies. News items and extracts of Council actions appear regularly in *Michigan Medicine*. Delegates or component society officers who have questions about items that follow are urged to contact the MSMS Councilors or the MSMS staff.

MSMS Membership

Membership in MSMS on Dec. 31, 1972 stood at 8,168—a record figure. The gain over the previous year was modest, but many other professional societies are experiencing declining membership. The June 1973 membership shows a gain of 115 members over the June 1972 figures. Following are the MSMS membership figures:

Year	*June 30*	*Dec. 31*
1935	3410	3543
1945	4425	4686
1955	5503	6109
1960	6660	6715
1965	7247	7563
1970	7643	8062
1971	7645	8101
1972	7741	8168
1973	7856	

Finances

Expenses for 1973 are in line with the estimates in the budget. Authorized increases in the budget were $2,000 for additional mailings to members regarding Medicaid; $3,000 for expenses for the Ad Hoc Committee to Coordinate Professional Standards Review Organizations in Michigan; $580 for printing MSMS Constitution and Bylaws; $900 for "Medical Memo" project, and $150 for Medical Assistants promotion.

Dues income for 1973 will be approximately $10,000 higher than the budgeted amount. Other income accounts will reach their 1973 estimates.

Following is a balance sheet for the eight-month period ending July 31, 1973. It shows the status of our assets and liabilities and the resulting members' Equity.

ASSETS		
CURRENT ASSETS		
Cash	$ 16,547	
Accounts Receivable	10,832	
Pension Trust & Due from Employees	11,359	$ 38,738
INVESTMENTS IN SHORT TERM SECURITIES		575,000*
INVESTMENTS IN FUNDS		
Capital Reserve Fund		458,105
Capital Protection Fund		386,243
FIXED ASSETS		
Building	606,235	
Furn. & Equipment	114,983	
Less: Accumulated Depreciation	183,906	537,312
Land		75,971
OTHER ASSETS		
Prepaid Expense		3,034
		$2,074,403
LIABILITIES AND MEMBER EQUITIES		
CURRENT LIABILITIES		
Accounts Payable (Est.)		19,000
Property & Other Taxes Payable		9,812
LONG TERM LIABILITY		
Mortgage Payable		593,022
Long Term Liability to Retired Exec. Dir. (Funded as part of short term securities)		9,800
MEMBERS' EQUITY		
Members' Equity (Net Worth)		$1,442,769
		$2,074,403

*$575,000 Short Term Investments (Operational Fund)

Committee Activity

The many MSMS committees continue their effective work, researching and discussing matters of interest, recommending courses of action to The Council for approval, and then implementing programs authorized by The Council.

The 49 MSMS committees during the past year held a total of 89 meetings, most of them at the MSMS headquarters.

The Planning and Priorities Committee will make recommendations to the 1973 fall meeting of the House regarding committees and their structure.

Pending action by the House, The Council generally has continued the ongoing committees and experimented with ad hoc task forces for specific assignments.

The chairmen and members of the MSMS committees merit the appreciation of the MSMS members for the many hours of devoted study and follow-through. The detailed minutes of all committee meetings are on file at the MSMS headquarters for the review of any interested member.

Interested members may report their desires to serve on an MSMS committee through their component society president, their Councilor or direct to the MSMS headquarters.

Planning and Priorities Report

The MSMS Committee on Planning and Priorities will present some recommendations to The Council and the MSMS House of Delegates this fall. One set of recommendations will propose a regrouping of committee work into more logical "divisions" and another set of recommendations will propose changes in structure and operations. The committee chairman indicates that the proposed improvements are orderly and deliberate rather than revolutionary.

The Committee presented recommendations about possible changes in the MSMS Purposes, which were adopted by the House at the spring meeting. At that time, the House also concurred in the Committee's identification of a series of "current goals" and a series of longer-range "intermediate goals."

Stuart Gould, MD, Chairman, reports that he has had excellent cooperation from committee members, who have worked effectively both in smaller subcommittees and as a committee of the whole.

Liaison with Specialty Organizations

The Council has continued its relationship to the newly formed independent Council of Medical Specialties. Its moderator, Glenn Moore, MD, Flint, was reelected this past year. The MSMS Past President, Harold Hiscock, MD, serves as Permanent Advisor to the group.

The Council of Medical Specialties meets periodically at the MSMS headquarters, studies problems of common concern to its membership and receives reports of special interest from MSMS officers and staff.

The Council of MSMS has referred to the Council of Medical Specialties the task of gathering information (with the cooperation of MSMS staff) regarding national norms for local adaption by regional PSROs. The MSMS Bureau of Economic Information and MSMS consultant, Harold Falls, MD, Ann Arbor, are collecting material which will go to the Council of Medical Specialties and then to The MSMS Council and the local PSROs for local adaption.

MSMS has repeated its offer to the representatives of the specialty societies in Michigan to provide secretarial service for a negotiated reimbursement fee. This year agreement was reached between the Michigan Psychiatric Association and the MSMS for the establishment of a permanent "office" in the MSMS headquarters with Miss Helen Schulte serving as the part-time secretary of the MPA. This relationship follows the precedent set as MSMS served in a part-time capacity to the American College of Emergency Physicians three or four years ago.

The phase-in period will begin October 1973 and in June 1974, the MSMS executive secretarial service will be in full effect.

Liaison with Michigan Medical Service and Michigan Hospital Service

The House of Delegates was informed by The Council at its spring meeting that The Council believed there ought to be some communication between the MSMS and the MMS. A resolution suggesting specific ways in which this could be achieved was not voted upon, since The Council had informed the House that two committees were being appointed, one to be a liaison committee between the highest officers of MSMS and the highest officers of Blue Shield, and the other a liaison committee with MD members of the Blue Shield board. These committees have now been appointed, as well as a third committee to serve as liaison with other third party carriers through the Health Insurance Council.

Member Services

MSMS continued to offer a variety of benefits for MSMS members. These include:

Blue Cross/Blue Shield Economy Program. The Blue Cross/Blue Shield Econo-plan is now available on an individual optional basis in lieu of MVF-2 for MSMS members participating in the MSMS 94000 Blue Cross/Blue Shield group. Blue Cross benefits under the econo-plan are subject to a 30 percent co-payment up to a maximum of $600 for each inpatient admission, but this co-payment requirement does not apply to hospital outpatient care. Blue Shield benefits are subject also to a 30 percent co-payment feature without limitation to the amount of subscriber liability. Some of the benefits found under MVF-2, such as coverage for immediate maternity, outpatient psychiatric and convalescent care, and full payments for diagnostic X-ray and laboratory services, are not benefits of the econo-plan program. A subscriber physician electing the econo-plan rather than the MVF-2 plan would save approximately $29 per month on a full family contract ($76 vs $47).

Car Leasing Program. McCullough Leasing, Inc., the operator of the MSMS car leasing program, reports that as of June 30, 1973 MSMS members have 64 cars on lease. Monthly rates for 1974 models are detailed in a brochure that will be sent to all MSMS members as an enclosure in the September issue of *Michigan Medicine.*

Car Rental Discount. Final negotiations are being completed with the Avis Corporation for the MSMS car rental discount program. All MSMS members will receive cash cards entitling them to a 20% discount on cars rented in the continental United States, Alaska, Hawaii and Canada. Members renting cars elsewhere in the world will receive a 10% discount.

Disability Insurance. The MSMS disability insurance program has been broadened to offer interns and residents, under age 34, who become associate members of the MSMS, disability insurance at a very low cost. Specifically, $325 monthly indemnity on a Lifetime Accident-Five-Year Sickness Plan with benefits commencing first day for accident and sixteenth day for sickness is available at an annual premium of $10. This new offering assisted county medical societies membership campaigns to enroll younger physicians.

Blue Cross/Blue Shield Coverage for Widows of MSMS Members. The MSMS 94000 Group MVF-2 Blue Cross/Blue Shield benefits became available to widows of previous MSMS members, effective on August 1, 1973. In the future, widows will be notified of the availability of these benefits.

Basic Professional Liability Insurance. Johnson & Higgins continues its investigation of a possible professional liability program for consideration by MSMS. Johnson & Higgins has been successful recently in installing programs for both the Illinois and Louisiana State Medical Societies and the Northern California Physicians Council. The Johnson & Higgins Detroit office is now preparing new materials, including information generated by the survey conducted by the MSMS Bureau of Economic Information, for possible presentation to interested underwriters.

Physician Placement Services. A joint effort between MSMS and the Michigan Health Council was begun this year to increase county medical society involvement in the recruitment and placement of physicians. A questionnaire was mailed in July to select county medical societies as the first step toward determining priority needs for new physicians. An Ad Hoc Committee to confer with Michigan Health Council regarding future operation of the MD Placement Services for Michigan has been appointed.

Life Insurance Open Enrollment. An open enrollment for the life insurance program was conducted in February and March. Over 500 new applications were received and these new participants will add additional strength to this highly successful program.

Membership Activities

A current major direction of MSMS activity is toward attracting new members to provide new vitality and continual growth.

A number of efforts are underway to (1) reach out toward the many foreign physicians arriving in Michigan as interns and residents, (2) to contact practicing physicians who are not members of MSMS and (3) to increase the contributions of students, interns and residents in medical society activities.

MSMS sent a letter to non-member physicians inquiring about their interest in medical society affairs. From that group, MSMS was able to pass on to the appropriate county medical societies the names of 62 physicians who had expressed an interest in joining.

Peer Review

The MSMS peer review system, which is composed of (1) county society committees dealing with utilization or fee complaints, (2) regional medical advisory committees within each Councilor district and (3) the MSMS Committee on Utilization and Health Insurance Problems has dealt with utilization and fee problems brought to it by both Michigan Blue Shield and commercial health insurance companies. The MSMS Utilization Committee considered several matters on appeal.

Professional Standards Review Organizations

The Ad Hoc Committee to Coordinate PSRO Activity in Michigan in conjunction with county medical society leaders identified medical service areas and physician referral patterns throughout the state. This information was presented on August 28 by MSMS to HEW Region V in recommending PSRO area designations for Michigan. MSMS is awaiting a decision from HEW re PSRO designations for Michigan. The Committee is continuing its work with a counterpart committee of the Michigan Association of Osteopathic Physicians and Surgeons to organize a single state-wide service support unit to provide data processing and other supportive services to individual PSROs when they become established.

The Department of Health, Education and Welfare is preparing guidelines for developing an organization that will qualify as a PSRO. MSMS will transmit this information as soon as it becomes available along with prototypes to county medical societies.

Medical Economics

The Bureau of Economic Information was involved this year in many activities related to the area of socio-economics in the medical field.

The second Physician Fee Survey was mailed to the membership in June. Returns thus far are around 3,000. The results of this survey will be compared with the one conducted two years ago to determine how the economic stabilization program affected physicians' fees.

The Bureau staff interpreted to the membership the rulings established by the Price Commission re physician fees. It explained in *Michigan Medicine* how the guidelines actually functioned. Support data was supplied to the officers of the Society who formally protested Phase III guidelines as "unfair."

In March, the Bureau published its *Health Care Fact Book*, containing statistical tables and graphs relating to all areas of the health care field. Much research for current, available data went into the book. The fact book may be updated soon.

Much time was spent matching the three coding systems used most frequently for billing purposes, which are now printed in the 1973 Michigan Relative Value Study.

The Research Bulletin, with articles pertaining to the socioeconomic side of medicine, was mailed monthly to 450 selected MD leaders.

In April, a survey was conducted re availability of care to patients in Michigan. Primary care physicians in certain counties were asked to return a short questionnaire dealing with this topic. Results showed that a majority of physicians in these areas accept new patients, including those on Medicaid.

The Bureau is involved with PSRO criteria development. Besides working with various MSMS committees that are studying this, the Director of the Bureau has attended seminars and meetings with those from other agencies working on this same problem.

Bureau representatives participated in a Health Manpower Information System Task Force, led by the Michigan Department of Public Health and the Michigan Department of Education. Questionnaires were sent to those in the health fields who needed to renew their licenses, and the response was excellent. It is hoped that when this study is completed the state will be able to help determine what its needs will be in the future.

Because many physicians are concerned about the malpractice insurance situation in Michigan, the Bureau conducted a survey early in the year to find such data as the cost of insurance to physicians, the number of suits incurred, etc. The response was very good, and the data received is being used in working toward solutions.

The Bureau currently is researching the distribution of physicians in Michigan. As the data are tabulated, the MSMS members will be informed of the results.

Medicaid

Pursuant to action taken by the 1972 Fall House of Delegates, MSMS advised its members not to sign the then-provider agreement required for reimbursement for Medicaid services. The Governor's office invited MSMS leadership to meet with him to seek a solution to the impasse, and subsequently MSMS named an ad hoc committee to work with a specially-appointed Governor's committee to seek a solution to the problem. The committee, chaired by James Fryfogle, MD, Vice-Speaker of the House, concluded an agreement with the Governor's committee in mid-October on a new "Physician's and Dentist's Identification Form" which removed physicians' objections to portions of the former provider agreement and still provided the Medicaid program information required by the Department of Social Services. The two committees also agreed to deal with a number of problems between the department and physicians, and through a series of negotiation sessions succeeded in resolving several of them, including coverage for emergency services, coverage for outpatient psychiatric care and coverage for newborn infants of Medicaid mothers.

The major effort of the committee, however, was revision of the 109-question invoice form for Medicaid services. A number of sessions were necessary to eventually reach agreement on a shorter invoice form, which the Department of Social Services began to put in use in August, 1973.

At the March session of the House of Delegates, Dr. Fryfogle reported on the achievements of the ad hoc committee, and stated that it had carried out its charge and was dissolved.

The House then instructed The Council to appoint a permanent liaison committee with the Department of Social Services to deal with Medicaid issues. It instructed that the committee be "properly representative of physicians who regularly care for Medicaid patients and who have experience in billing for these services."

This new committee met with Medicaid officials on August 29. Members of the committee are: Dr. Fryfogle, Chairman; Richard D. Cecconi, MD, Iron Mountain; Thomas M. Flake, MD, Detroit; James D. Johnstone, MD, Traverse City; John L. Loomis, MD, River Rouge; Marion G. McCall, Jr., MD, Detroit; Robert M. Rice, MD, Greenville; David Siegel, MD, Lansing, and Robert J. Toteff, MD, Saginaw.

Legislation

While priority emphasis has been given this year to containing legislative efforts to permit substitution of brand names or generics for physicians' prescriptions and promoting a new medical practice act, two statutes supported by MSMS were adopted by the Legislature before recessing for the summer.

Senate Bill 187 (P.A. 47 of 1973) redefines transplantations as a service rather than previous definition as a sale, and eliminates warranty of product. House Bill 4518 (P.A. 75 of 1973) permits Blue Cross to contract with proprietary hospitals in contrast to the previous statute which limited Blue Cross to community non-profit hospitals.

The blood warranty bill has been introduced with joint MSMS and Michigan Hospital Association support. It is a direct response to an Illinois malpractice finding three years ago when judgment was found against defendant doctors, hospital and a bloodbank because serum hepatitis developed following transfusion. The bill does not have immediate effect, therefore is not effective until April 1974.

The Blue Cross-proprietary hospitals bill also had been introduced in previous years, without MSMS endorsement. When the Spring MSMS House of Delegates resolved to support "legislation assuring patients covered by such a policy (Blue Cross) that the benefits of that policy are obtainable in any hospitals licensed by the Department of Public Health and accredited by the Joint Commission in Accreditation," the legislation gathered impetus and passed both houses. The new statute is permissive, requiring Blue Cross to apply its minimum criteria for hospital standards.

MSMS has prepared for anticipated action in the fall legislative session on the proposed revised medical practice act, espoused jointly by the Board of Registration and MSMS. Main objectives of the rewritten bill are to provide flexibility in types of medical licensing, modern statutory language and structure (the current medical practice act was originally written in 1899, and has been often amended since), and adjustment to modern licensing examinations and medical education.

Anti-substitution repeal legislation was launched in both houses, with most action occurring in the House of Representatives. Two approaches have been made—one a straight repeal of anti-substitution laws, the other creation of a state pharmaceutical formulary. MSMS is vigorously opposing both bills.

Other bills in which MSMS took an active interest include several related to the Supreme Court ruling on abortion. Both regressive and progressive legislation has been offered.

Shortly after the State Department of Public Health issued guidelines for the control of abortion procedures, MSMS went on record endorsing the guidelines. House Bill 4582 and Senate Bill 345, introduced in the Legislature to give statutory teeth to the guidelines, have MSMS support. Neither has passed.

In anticipation of Health Maintenance Organization legislation at the state level, MSMS filed with the Governor's office an MSMS position paper on HMO legislation adopted by The Council. Introduction of HMO legislation can be anticipated this fall.

In addition to Senate Bill 187, two malpractice bills have been introduced. Senate Bill 489 would require an affidavit of merit with each complaint filed in court, and a 60-day "cooling off" subsequent to filing of suit. Senate Bill 809 would require written warranty in breach of contract claims. The latter responds to the Michigan Supreme Court decision of 1972 finding a Michigan physician guilty of breach of contract even though charges of malpractice were not substantiated. Neither bill has moved out of committee.

MSMS has representation on an ongoing study of the supply of family practice physicians in Michigan.

In conjunction with the Michigan Doctors Political Action Committee, MSMS continued in 1973 its reception for members of Congress from Michigan.

Sixteen members of MSMS participated in the Doctor-of-the-Week program during the spring session of the Legislature. Several doctors increased their own effectiveness by bringing their wives as guests. The popularity of the program in the State Capitol continues unabated. Physicians participated from Roscommon, Wayne, Delta, Lapeer, Midland, Monroe, Kent, Oakland, Eaton, Ingham, Livingston, Macomb, Muskegon, Newaygo, Calhoun and Jackson Counties.

Communications—Professional and Public

Michigan Medicine. The MSMS monthly journal continued to serve as the major channel for information to the members about the concerns and accomplishments of MSMS, and for the presentation of scientific papers as a part of the MSMS continuing medical education efforts. The companion newsletter, called "Medigram" was published twice each month to provide breaking news for the members about MSMS work on legislation, Medicaid, PSRO, socioeconomics, communications, etc. "Medigram" is mailed to hospitals for distribution to interns and residents and to the medical schools for distribution to medical students.

Advertising in the journal has decreased for several related reasons—some pharmaceutical firms have merged, there are fewer new products, and federal regulations on drug advertising have tightened.

Liaison with Component Societies. Direct personal contacts between component societies and Council members and staff have increased this year. President Coury, President-Elect Masters and Council Chairman Leitch have addressed many component meetings, and Councilors have tried to visit the units in their district. MSMS staff members have traveled many miles to make presentations to components and to help answer questions about Medicaid, PSRO, etc. Workshops were held in 1973 for the incoming presidents of the components and for the secretaries and executives. In the spring MSMS unveiled a new 2 x 2 colored slide story about MSMS and this is offered to components for their 1973-74 fall and winter programs.

MSMS headquarters staff members carried out a systematic, year-round distribution of important reports to the component presidents, presidents-elect, secretaries and executives, and also to component committee chairmen when appropriate.

Liaison with Other Organizations. Once again, MSMS officers, committees and staff members worked with many organizations on common projects. Liaison was increased with both the state Woman's Auxiliary and the state society of medical assistants by the appointment of representatives as advisors to the MSMS Committee on Public Relations. MSMS continued to operate the SAMA-MECO student summer placement bureau in cooperation with the three SAMA chapters. In recalling good liaison work with the Michigan Hospital Association, Michigan State Nurses Association, Michigan Dental Society, the medical specialty societies, etc., The Council notes especially the closer cooperation with the Wolverine Medical Association and its Detroit component, and with the Michigan Association of Osteopathic Physicians and Surgeons.

Communications with the Public. The annual report of the MSMS Committee on Public Relations describes the varied MSMS efforts to reach the public through the press, radio, television, publications, conferences, etc.

Continuing Medical Education

MSMS continued to provide postgraduate medical educational opportunities for physicians, medical students and nurses.

1972 Annual Scientific Session. The 1972 program was composed of general meetings, Section meetings, specialty meetings and postgraduate courses. A total of 147 speakers, moderators and discussants presented the educational lectures, panels and courses.

1972 Fall Series. The last annual autumn-winter postgraduate program, as arranged by the Committee on Postgraduate Medical Education, sent speakers into 18 communities in the lower and upper peninsulas. As in past years, this program was in cooperation with the three medical schools and the Michigan Department of Public Health. No budget has been allocated for continuing the spring and fall programs, pending evaluation of the total MSMS postgraduate education effort.

Annual Conference on Maternal and Perinatal Health. The 1973 spring conference in Lansing drew more participants than ever before. Subjects of special interest to obstetricians-gynecologists, pediatricians, pathologists, anesthesiologists and family practitioners were presented. This meeting is provided without fee to physicians, nurses, students and others concerned with the care of the mother and her child, by the generous support of the Michigan Department of Public Health, many specialty groups, the local component medical society and pharmaceutical houses.

A two-day conference again was held in May at the MSU Gull Lake Conference Center. This meeting is arranged for members and guests of the Committee on Maternal and Perinatal Health.

Conference on Medical Aspects of High School Sports. The eighth annual conference for team physicians, coaches and trainers was held in Lansing under the leadership of the Committee on Medical Aspects of Organized Athletics.

Commission on Continuing Medical Education. The Commission has been appointed as ordered by the House of Delegates and held its first meeting on August 15. The Commission has been assigned the development of a flexible series of minimal continuing medical education standards for physicians practicing in Michigan; the establishment of basic principles of approval for all continuing medical education programs in the State; and, guidelines for reciprocity with accredited programs of other state, regional and national organizations.

Study of Internships

MSMS has appointed six physicians to an ad hoc committee to study possible changes in the present internship operations in Michigan. Early thinking about a possible statewide postgraduate medical education system in Michigan was outlined to The MSMS Council in March. The Council took no stand but named representatives to the study committee. Representatives of the MSMS, MAOPS, the Michigan Association for Medical Education, the medical schools, etc., are evaluating the present internship programs.

One possibility under study is that of requesting the state legislature to help finance the training of interns in Michigan. The August issue of *Michigan Medicine* contained special articles on this subject.

This report contains information on Council and Society activities through Sept. 15, 1973. Any subsequent Council action taken prior to the October, 1973, Annual Meeting will be reported in the Chairman's Remarks to the House of Delegates.

COMMITTEE REPORTS

15. Annual Summaries of Council Committees

Committee on Aging

Jack F. Sanders, MD, *Chairman*

An informal, exploratory meeting with the Committee on Health Care for the Aging, of the Michigan Nurses Association, was held on February 14, 1973 to review and evaluate problems of health care in Michigan and to determine methods of collaborative activity to protect the interests of the aging. General discussion included: an exchange of objectives and philosophy; the advocacy role of professional associations to the aging (particularly those in long-term care facilities); a review of current concerns and activities; and possible joint endeavors on behalf of the aging.

The MNA seeks MSMS support to strengthen the position of the Michigan Department of Social Services in their efforts to develop appropriate standards to protect the welfare, rights, and health of residents who reside in adult foster care facilities.

An exchange of correspondence between the Michigan League for Nursing and the Committee may result in liaison or a meeting involving in-home services to the aging.

The MSMS Council on March 2, 1973, approved the appointment of Committee member Harvey M. Andre, MD, to serve on the Michigan Commission on Aging Technical Review Committee.

Bradley M. Harris, MD, represented MSMS and the Committee during the 26th Annual Conference on Aging in Ann Arbor, September, 1973.

Committee on Alcohol and Drug Dependency

Richard C. Bates, MD, *Chairman*

The Committee met on Sept. 6, 1972, Dec. 13, March 28, and May 17, 1973.

The Committee, in conjunction with the Office of Drug Abuse and Alcoholism, State of Michigan, and many other organizations and groups, sponsored an educational workshop on alcoholism and drug abuse at the MSU Kellogg Center in East Lansing on Sept. 19-20.

The Committee considered legislative matters concerned with alcoholism and drug dependency and continued its liaison with the Michigan Department of Public Health, the Office of Drug Abuse and Alcoholism, State of Michigan, and other agencies.

A special joint meeting was held with the members of the newly-formed Committee on Drug Abuse and Alcoholism of the State Bar of Michigan. The main reason for the meeting was to get the group together and acquainted and to find out the work, responsibility and interest of each committee member. Sometime in the future, another meeting of these two groups will be held.

The major work of the Committee in the past year was consideration of the problem of physicians with psychiatric disorders, including alcoholism and drug dependency. A special report on this subject was sent to The Council on May 13, 1973, with the result that the Committee on Alcohol and Drug Dependency has been authorized to develop a program for "the addicted physician" along AMA guidelines, this program to include clearly-stated (a) objectives, (b) procedures for diagnosis, (c) procedures for treatment, (d) procedures for ongoing status evaluation, (e) recommendations for patient and public protection. The Committee has been requested to submit its recommended program to The Council for adoption within six months' time.

Committee on Computers

Robert M. Stow, MD, *Chairman*

This Committee was created by Resolution 17 of the 1971 House of Delegates and charged with keeping abreast of developments in the computer field and advising The Council on needs for legislation, changes in accreditation requirements and other matters which would logically come before the Committee.

The Committee is composed of physicians from the major medical service areas within the state, and is continuing to coordinate individual efforts toward an eventual integrated statewide hospital and medical information system.

Ad Hoc Committee to Coordinate PSRO Activity in Michigan

John R. Wilson, MD, *Chairman*

The Committee was appointed by The Council in January 1973 and charged with the responsibility of developing a state coordinated, locally operated, plan for professional standards review organizations in Michigan.

The Committee in conjunction with county medical society leaders identified medical service areas and physician referral patterns throughout the state. This information formed the basis for MSMS testimony presented on Aug. 28, 1973 to Department of Health, Education and Welfare, Region V, representatives recommending PSRO area designations for Michigan. While awaiting a decision in this regard from the HEW Secretary, the Committee is continuing its work with a counterpart committee of the Michigan Association of Osteopathic Physicians and Surgeons to organize a single state-wide service support unit to provide data processing and other supportive services to individual PSROs when they become established.

The Department of HEW is preparing guidelines for developing an organization that will qualify as a PSRO. The Committee will transmit this information as soon as it becomes available along with prototypes to county medical societies.

Committee on Eye Care

Robert T. Blackhurst, MD, *Chairman*

The Committee met on Jan. 24, 1973.

The Committee continues to serve in an advisory capacity and as resource persons and/or consultants to other members of the profession, other MSMS committees, the Bureau of Maternal and Child Health of the Michigan Department of Public Health, the Division of Services to the Blind of the Michigan Department of Social Services, educators, legislative and government persons, and to other groups, organizations, persons, etc., when advice and counsel on ophthalmological matters are indicated.

The Committee heard reports on and gave recommendations concerning preschool and school vision screening follow-ups and referrals, programs for children and families receiving ADC, diabetes in youth, the Lions' Sightmobile Program, vision screening standards for driver's licensing, the library for the blind and physically handicapped, and vision tests for infants.

The Committee reviewed the screening program and other activities of the vision section of the Michigan Department of Public Health, Bureau of Maternal and Child Health.

Committee on Hospital Relations

Lewis E. Simoni, MD, *Chairman*

Although no formal meetings with the Michigan Hospital Association were held, discussions of mutual interest continued between staffs.

Staff attended a MHA meeting on Nov. 17, 1972, to describe the mechanics of MSMS political activity via MDPAC and AMPAC for background information if MHA adopts similar legislative activity.

Education Liaison Committee

Brock E. Brush, MD, *Chairman*

This Committee met Jan. 11, 1973 and will meet again Sept. 17, 1973. Several informal working sessions were held between members of this Committee on the Liaison Committee with Medical Students in order to complete a report to the spring meeting of the MSMS House of Delegates.

Major topics for the Committee this past year were:

1. *Implementation of 1971 House of Delegates Resolution 54.*

This resolution instructed the speaker to appoint a committee to study the emigration by some Michigan medical school graduates to other states for internships and residencies and to make recommendations to help minimize this loss. The resolution specified that the ad hoc committee should be composed of academic and practicing physicians and medical students, so the speaker merged these two committees as the ad hoc task force because together they met the requirements. Some statistics were obtained, and many discussions were held by members with students, with directors of medical education, with component society officers, with interns and residents, etc., and a set of 14 recommendations were presented to the spring meeting of the MSMS House. These were adopted and appear in the August issue of *Michigan Medicine* with the proceedings of the 1973 spring meeting. Efforts are now underway to implement the suggestions, and the subjects will comprise the major work of the Committee for 1973-74. The Chairman thanks the Chairman of the Liaison Committee with Medical Students, George Koepke, MD, for his fine work in compiling the report and testifying before the spring meeting of the MSMS House.

2. *SAMA-MECO Project.*

The Committee provided advice and guidance to the MSMS Department of Communications which handled the placement of 105 medical students for the summer of 1973 in 56 hospitals across the state. This is a sharp increase over the 11 students placed in 1970, the 50 students in 1971, and 92 in 1972. There were many other interested students who could not be placed because sufficient spots could not be identified. The Committee thanks the community hospitals, the hospital administrators, and the local physicians who participated in this orientation program for the students, most of whom were sophomores. Cooperating again were the three SAMA chapters, Michigan Hospital Association and the Michigan Academy of Family Physicians. The project results in much positive newspaper coverage and the MSMS work is much appreciated by the medical students.

3. *Financial Needs of Students.*

This matter has been under discussion by the Committee, which recommended to the House along with the other recommendations, that an ad hoc committee be established to focus in on this concern. Such a committee has been appointed and can be expected to report to The Council and/or House in 1974.

4. *Physician Assistant Program at Western Michigan University.*

The Committee continues to receive progress reports from WMU which enrolled its first class of students in the fall of 1972. MSMS endorsed this WMU baccalaureate primary care physician assistant program several years ago. The Committee is cooperating with the MSMS Committee on Legal Affairs to obtain the necessary legislation in Michigan so when these students graduate the physician who employs them and the physician assistant both will have questions clarified regarding liability, etc.

5. *Preceptorships.*

MSMS used *Michigan Medicine* and *Medigram* to explain the new federally-funded program conducted jointly by the medical schools to place students with family physicians, pediatricians and internists for preceptorships. MSMS has helped to recruit interested physicians to serve as preceptors (teachers).

6. *Review of Report H from the 1972 winter meeting of the AMA House of Delegates.*

The Committee evaluated the proposed AMA Council on Medical Education position paper on "Functions and Structure of a Medical School." The Committee found the report generally acceptable and so informed the AMA delegation from Michigan. The report, with some modifications, was adopted by the AMA House of Delegates in June 1973.

7. *Request from Saginaw Valley College.*

The MSMS Council in December heard a presentation by Samuel Marble, Ph.D., President of the Saginaw Valley College, asking MSMS support for a proposed six-year, masters' degree in human biology. The Council referred the matter to the Education Liaison Committee. The Committee invited Doctor Marble to its January 11, 1973 meeting and two representatives were sent because Doctor Marble was on a sabbatical. Questions were raised about whether SVC was planning a two-year medical school or not. After considerable discussion the Committee voted to defer further study and any reply to SVC until the SVC requested site visit is made by a joint team from the AMA and the American Association of Medical Colleges. Such a report was approved by the MSMS Committee in January. The state legislature has since provided some funds to SVC to plan its curriculum. The matter—especially the possibilities of a new two-year medical school—continues under study by the Committee.

Liaison Committee with Medical Students

George H. Koepke, MD, *Chairman*

This Committee met with the SAMA delegates to the MSMS House of Delegates during the fall 1972 MSMS House meeting, and several members met informally with representatives of the Education Liaison Committee to prepare a joint report to the 1973 spring meeting of the MSMS House.

This matter is described under the annual report of the Education Liaison Committee, so it is not repeated here.

The Liaison Committee with Medical Students is helping to implement the recommendations made by the joint committee and approved by the spring House to help reduce the exodus of Michigan medical school graduates to other states.

Committee on Medical Aspects of Organized Athletics

Robert H. Evans, MD, *Chairman*

The Committee met Jan. 31 and April 5, 1973, and most of the Committee members participated in the 1973 MSMS Conference on Medical Aspects of High School Sports, April 5, 1973 in Lansing.

A total of 125 participants registered in the annual conference held this year for the first time off campus at the Hospitality Inn, off the expressway south of Lansing. Committee members felt the location was good, and the conference did not suffer from not being on the MSU or U-M campuses.

The Committee continued its study to develop a better approach to the pre-season physical examinations that are required by the Michigan High School Athletic Association. A proposed new medical record was developed by Robert E. Anderson, MD, and sent to members of the Committee for decision at a future meeting. Al Bush, director, MHSAA, has conferred with the Committee several times on this project.

The Committee also has discussed wrestling weights, certification of athletic trainers and other related matters.

Ad Hoc Committee to Meet with Michigan Health Council

Leland E. Holly, II, MD, *Chairman*

The Committee met on Sept. 19, 1973.

A meeting has been scheduled with Michigan Health Council representatives on Nov. 6, 1973. A major topic to be discussed will involve seeking methods to increase active liaison and partnership in placement and recruiting in counties that have physician shortages.

Liaison Committee with the Michigan State Pharmaceutical Association

Robert E. Rowe, MD, *Chairman*

The physician members of the Liaison Committee met on January 4, 1973. Representatives of the MSPA had been invited to attend a full meeting of the Committee following the MSMS members' session, but declined on the basis that there were no matters needing joint discussion at this time.

MSMS and MSPA have been working to establish procedures for future meetings and have agreed that it is not improper for the respective association members to meet separately when there are subjects for discussion that are not matters of mutual concern. There is mutual agreement that continuing liaison and communication are desirable and beneficial to resolve problems that develop between the two professions and the Committee should work to formulate joint health programs.

The Committee received notification that the Michigan Board of Pharmacy had rejected the 1971 MSMS Resolution 24 urging amendment of the Pharmacy Act to allow registered nurses, on written policies and procedures adopted by a hospital pharmacy and/or therapeutics committee, to dispense medications ordered by a qualified physician in the absence of a registered pharmacist.

The Committee considered the problem pharmacists experience when illegible signatures make it difficult to identify the prescriber, particularly on medical institutional prescription blanks where only the institution name is preprinted.

The problem is compounded when residents or interns sign the prescription blank and the pharmacist is unable to identify the signature to contact him for consultation. The Committee agreed that pharmacists should not handle unreadable prescriptions and acted to insert an article in *Michigan Medicine* to impress upon house staffs using hospital prescription blanks the importance of making certain that their signatures are decipherable.

Legislative proposals to repeal the existing drug antisubstitution law were a matter of serious consideration by the Committee. The position of the Michigan State Medical Society to oppose and resist all attempts to repeal antisubstitution laws was strongly endorsed by the physician members of the Liaison Committee. The MSMS Legal Affairs Committee has been charged with implementation of the MSMS position.

Committee on Rehabilitation

Stuart L. Cohn, MD, *Chairman*

The Committee held meetings on May 17 and on June 12.

The Committee met with representatives of Michigan Blue Cross to discuss the Rehabilitation Demonstration Project. Some years ago auto workers identified the need for increasing rehabilitation coverage of members and in 1970 negotiators were able to have a demonstration project accepted on rehabilitation of some of the chronically ill and disabled workers and their families. The program is to start in October of 1973.

The premise on which this project is based is that the concept of rehabilitation is embraced by most of the physicians, but because of limited facilities and relative lack of understanding on the part of many physicians as to the exact nature and role of rehabilitation in the continuance of medical care, they either have patients in need of rehabilitation, or who are not channeled into the appropriate centers, or if they are the planning is not appropriate. The Rehabilitation Demonstration Project, as approved by The Council, will improve the referral and treatment procedures in programs for patients with disabling conditions. If the project appears to have merit after twelve to eighteen months of study, there well may be additional benefits such as the provision of durable medical goods and future Union-Management contracts.

The Committee also heard reports on the Medicare guidelines being developed by the Michigan Department of Public Health; reviewed activities of other state medical society rehabilitation committees; and discussed ways to encourage more physicians to enter the field of physical medicine rehabilitation and to urge those already in practice to refer their patients to the appropriate facility and/or agency for the rehabilitation services they need to make them productive citizens again.

Committee on Relative Value Study

John B. Bryan, MD, *Chairman*

The Committee held meetings on Jan. 31, April 11, and May 14.

The Committee members were given the task of matching the CPT, NABSP, and old MBS code numbers. This required a good deal of effort on the Committee members' part. They were aided greatly by the Bureau of Economic Information. The Bureau's staff did the matching and assembling of information for the members to approve. The culmination of their efforts was the printing of the 1973 Michigan Relative Value Study.

The Committee is looking into the feasibility of having the third edition of the AMA's Current Procedural Terminology computerized for the purpose of future publication.

16. Annual Summaries of Standing Committees

Advisory Committee to the American Association of Medical Assistants, State of Michigan

Paul T. Lahti, MD, *Chairman*

The Advisory Committee to AAMA, State of Michigan is pleased this year to note several significant changes in relation to physician awareness and backing of the active AAMA program in Michigan.

In January, Council adopted a motion that MSMS support membership in the American Association of Medical Assistants and recommended that physicians consider paying these dues for medical assistants in their offices.

The MSMS Public Relations Committee asked that two Medical Assistants act as advisors to their Committee, and further requested two other Michigan AAMA members to work on the MSMS Public Relations Task Force Committee.

Out of this Task Force Committee evolved a highly successful telephone techniques clinic which was presented at several key areas in Michigan for any physicians' employees who wished to attend. It is hoped that this clinic can be put into kit form to aid other areas in Michigan to plan their own clinics.

The *Michigan Medigram* published a full page article encouraging physicians to back their medical aides in membership to AAMA. The response has been encouraging and the members of this Committee wish to thank the Society for such excellent recognition and support.

Advisory Committee to Woman's Auxiliary

Fleming A. Barbour, MD, *Chairman*

It has been my privilege to serve as Chairman of the Advisory Committee which has as its members Doctors Charles Schoff, William Jones, and Harold Hiscock. In keeping with the theme of TELSTAR, which has proven to be an extremely effective method of stimulating auxiliary interest and programs, I wish to "TEL" how grateful we doctors are for the hard work and solid achievements of our auxiliary wives. We appreciate the opportunity of being "on call" as advisors.

Committee on Cancer

Robert W. Talley, MD, *Chairman*

The Committee met on May 23, 1973.

At this one meeting of the Committee, the members discussed the future of cancer programs no longer to be financed by the Michigan Association of Regional Medical Programs. The Committee felt very strongly that the State Society should continue to have influence on future planning in the various communities throughout the state regarding cancer detection, control and treatment. There is a need for better cooperation between various institutions in Michigan to make expert knowledge available to all and there should be better coordination of cancer efforts in a university environment. The medical schools in Michigan should have a professorship in cancer and student education should be aimed toward the total control and treatment of cancer patients.

The Committee is also considering the development of a booklet on the correct staging of types of cancer; a study on the importance of tumor registries; and the possibility of publishing data regarding staging of all tumors that have national or international recognition.

Committee on Children and Youth

John M. Dorsey, Jr., MD, *Chairman*

The Committee met on Nov. 28, 1972 and on April 11, 1973.

As the Committee has done in past years, it reminded the Michigan Department of Education to request school administrators, coaches and teachers, to be aware of the health hazard to children resulting from crash diets designed to produce rapid and extreme weight loss in athletes, who then participate or compete in a lower weight class which their coaches feel will give them an advantage in competition.

Educational materials for diabetic patients were reviewed and, inasmuch as national statistics indicate an increase in this disease, the Committee felt that the State Society should have a special committee appointed to study diabetes in children, youth and adults, including the need for genetic counselling. Such a recommendation was made to the Committee on Planning and Priorities.

The Committee was also involved in discussions on the following matter: Medicaid screening program for children entitled "Early and Periodic Screening, Diagnosis, and Treatment Program." Michigan's component societies were requested by the Committee to make every effort to assure medical input into this program at both the local and state levels.

The Committee discussed screening program versus physician physicals; the migrant and rural health program being conducted in Berrien County and in the Traverse City area; intensive infant care centers; the school food and nutrition program; physician assistants, retarded children and the special education program in public schools; safety glass law and other legislation, and miscellaneous matters as indicated by members of the Committee.

Committee on Governmental Medical Care Programs

Robert E. Rice, MD, *Chairman*

This Committee met four times during the year, issuing a number of reports with recommended MSMS action relative to federal governmental programs. The appointment of an MSMS Liaison Committee to deal specifically with the State on Medicaid issues permitted the Governmental Medical Care Programs Committee to concentrate its efforts in the field of federal legislation and programs.

Of overriding interest to the Committee and to doctors in Michigan, and throughout the Nation, was Congressional enaction of PL 92-603, the omnibus Social Security law of 1972. The impact of this law, with its provisions for Professional Standards Review Organization, and several other medical-related sections, will be felt by physicians for years to come.

Following are actions taken by the Committee:

PSRO: The Council referred consideration of the act to the Committee in November. Shortly thereafter the Chairman, with John Wilson, MD, Grand Rapids, and Kenneth Ray, MD, Grosse Ile, visited Washington, D.C., in a field study with HEW officials and AMA staff. Subsequently, the full MSMS Committee reviewed reports of the visitation subcommittee, and reported to The Council on only the PSRO section of PL 92-603 (See *Michigan Medicine*, February, 1973). The Council then authorized a special committee to be formed to take over PSRO implementation for MSMS, based on the Governmental Medical Care Committee's report and recommendation that MSMS involve itself deeply in PSRO, and its cautionary statement that massive amounts of work would ensue. Doctor Wilson, an original study subcommittee member, became chairman of this committee.

PL 92-603: The Governmental Medical Care Program Committee, its obligation re: PSRO complete, then turned its attention to the remainder of PL 92-603. In March it reported its analysis of the omnibus bill. The report, which took the form of a compilation of ingredients in the bill, recommended "that MSMS members be informed to the fullest extent possible." Council concurred.

HEALTH MAINTENANCE ORGANIZATIONS: The Committee, which had been involved in HMOs in previous years, moved on two fronts. At the request of the State Department of Social Services, the Committee provided a response to a white paper by the Department which was prepared for developing, in preparation for entering into contracts for some Medicaid services via HMOs.

The Committee also reviewed proposed Federal HMO legislation being proposed in the House and in the Senate. The Council referred the report back to the Committee, which has since monitored congressional activity. On September 12 the U. S. House adopted HR 7974. The Senate earlier had enacted SB 14, which is much more far-reaching than the House version. House-Senate Conference Committee now will take up the two bills for compromise.

NATIONAL HEALTH INSURANCE: The Committee has kept abreast of developments in National Health Insurance proposals. It considers this topic to be its primary charge in the coming year and are preparing comparisons of the various proposals for the enlightenment of Michigan physicians and possibly some recommendations for support or opposition.

STATE HEALTH FACILITIES: COMMISSION: The Committee recommended Edward J. Klopp, MD, Battle Creek, to the new State Health Facilities Commission, which reviews certificate of need applications and appeals. The Council concurred, and the Governor subsequently appointed Doctor Klopp.

Committee on Highway Injury

Paul W. Gikas, MD, *Chairman*

The Committee was active throughout the year, although no formal meetings were held in 1973.

The Medi-Label Project was re-vitalized under the direction of the Highway Injury Committee, and the response has been outstanding. Nearly 1,000 physicians have requested over 100,000 labels, and requests still are coming in each day.

The Medi-Label is a small label that can be affixed to the back of a driver's license, on which a physician (and only a physician) records vital information concerning his patients' health so, in the event they should be in an accident or otherwise seriously injured, those who are responsible for giving emergency treatment will be alerted to such special conditions as diabetes, allergies, blood type, tetanus immunization date, etc.

This successful project is a joint effort of the Michigan State Medical Society, the Michigan Association of Osteopathic Physicians and Surgeons, the Michigan Department of Public Health and the Michigan Department of State.

Also, via ballot vote, the Committee overwhelmingly elected to urge the Michigan State Medical Society, through its Legal Affairs Committee, to work for passage of a bill by the Michigan Legislature which would require the mandatory use of seat belts in automobiles.

Committee on Legal Affairs

Thomas H. Berglund, MD, *Chairman*

Legal Affairs (State Legislation) Committee met 5 times during the year. The principal charge to the Committee is to review legislative bills as they affect physicians and the practice of medicine, and to promote favorable medical legislation. It also maintains liaison and supervision of the so-called Capitol Building "Doctor-of-the-Week" program.

The Committee became directly involved in a number of pieces of legislation:

PHYSICIAN'S ASSISTANT: MSMS was deeply involved in enactment of PA 312 of 1972, which authorizes a commission to develop criteria for quality control of physician's assistants.

LABORATORY "KICKBACKS": With the Michigan Pathology Society and the Department of Public Health, MSMS supported legislation proscribing a laboratory or its agent from paying physicians to submit specimens.

PROPOSED NEW MEDICAL PRACTICE ACT: This is a proposal designed jointly by the Board of Registration in Medicine and MSMS. Its four main objectives are to modernize language and structure of the current 1899 statute, provide alternative types of licensure to full licensure ("temporary," "limited"), provide the "sick doctor act" in Michigan, and to modify licensure requirements to meet modern educational programs. After three years of exposure and legislative liaison, action on the proposal appears imminent.

PHARMACY ANTI-SUBSTITUTION REPEAL: Legislation which would repeal the anti-substitution clause in the Pharmacy Practice Act, and legislation to establish a drug equivalency commission to develop a drug formulary, have been introduced in the 1973 Legislature. MSMS' adamant opposition to anti-substitution repeal has been an influencing factor in thwarting action thus far. It does appear, however, that some kind of consumer-oriented legislation will pass, at least the House of Representatives, in 1974. The Legal Affairs Committee is maintaining vigilence on developments to have its greatest effect on the outcome.

MALPRACTICE LEGISLATION: The Committee has been striving for several years to achieve modification of current statutes which encourage professional liability actions. One gain was achieved in 1973 by passage of Senate

Bill 187 (PA 47 of 1973) which provides immunity to physicians, hospitals and blood banks when hepatitis occurs subsequent to transplantations. The Act will take effect in 1974.

Two other pieces of malpractice legislation lie before the Michigan Senate. Senate Bill 487 would require an affidavit of merit by an expert resource person when a malpractice complaint is filed; SB 489 extends to all licensed professional practitioners in the State. SB 809 would require warranties in writing when breach of contract suits are filed.

MSMS had effect in preventing several items from passage. Although still liable for action, proposals opposed by MSMS and apparently put aside include bills to require RH testing at birth, to require sickle cell tests at birth, to establish a State-operated College of Optometry, to require "open staffing" in hospitals and several to impose restrictive regulations on abortion procedures.

Bills which MSMS has supported and which have passed include one to remove from the state school code—smallpox vaccination requirements; and, one to permit Blue Cross to contract for services in proprietary and for-profit hospitals.

The Legal Affairs Committee has recommended to The Council that MSMS seek legislation to limit the practice of acupuncture to teaching and research settings. It also has recommended that Michigan emulate the State of Oregon, which has enacted a law directing health insurance companies and state agencies to use one uniform physician invoice form.

The Committee responded at length to a state request to react to proposed Health Maintenance Organization legislation, clearly stating the conditions under which MSMS could support such legislation and warning against unfair subsidies to HMOs at the expense of traditional modes of practice.

Under the aegis of Legal Affairs Committee, the Department of Government Relations has begun publishing a monthly report on legislation during session of the Legislature. It is mailed to officers, councillors, component medical societies, and other members of MSMS upon request.

Committee on Maternal and Perinatal Health

Richard T. Mellis, MD, *Chairman*

The Committee held meetings on Sept. 14, 1972, Jan. 11, March 21, and May 10-11, 1973.

The Annual Michigan Conference on Maternal and Perinatal Health was held for the twelfth year and was again a very successful postgraduate endeavor.

The yearly postgraduate meeting for members of the Committee was held at the MSU Biological Station at Gull Lake in May.

The Committee has continued its publication of Desk Reference Cards for use by individual physicians and hospitals; its sponsorship of the Conference for Expectant Parents; its liaison with the Michigan Department of Public Health and the Detroit Maternal and Infant Care Projects; its sponsorship of the Placental Tissue Registry; and, its work in connection with maternal death case histories, maternal mortality, perinatal morbidity and mortality, professional lay education, and the regional maternal mortality meetings and studies.

The Subcommittee on Better Utilization of Obstetrical Beds has been very active during the year and has conducted hearings with representatives of the following areas: Adrian, Ann Arbor, Benton Harbor-St. Joseph-Watervliet, Grand Rapids-Holland, Hillsdale-Jackson-Lenawee, Kalamazoo-Battle Creek, Lansing-St. Johns-Charlotte, and Petoskey. The Subcommittee has no legal or regulatory authority or function, rather, the Subcommittee hopes to provide assistance to physicians and others involved in the health planning process at the community level, particularly as that planning relates to provision of obstetrical and newborn services.

Other special studies being undertaken by the Committee are the high-risk pregnancy, maternal and neo-natal intensive care units, regionalization, reporting on infant deaths, legislation and autopsy-maternal deaths, perinatal statistics, abortion, protocols on maternal deaths and causes of stillbirth.

Liaison Committee with the Department of Social Services Re: Medicaid

James D. Fryfogle, MD, *Chairman*

Subsequent to the 1972 Fall session of the House of Delegates, an ad hoc committee was appointed jointly by the President, the Speaker of the House, and the Chairman of The Council, to deal with the Department of Social Services on a specific item relative to the Medicaid program. That was the then-Provider Agreement, which apprised doctors to commit themselves to far more in caring for Medicaid patients than doctors were willing to do.

The first ad hoc committee was composed of James D. Fryfogle, MD, Chairman; and Doctors Paul T. Lahti, David Siegel, Robert Toteff, and Brock Brush, Vice Chairman of The Council. This Committee functioned through May of 1973 and achieved a number of agreements with the Department, most notably a resolution of the provider agreement and drafting of a shorter and more acceptable Medicaid invoice form.

In May, the Spring House of Delegates adopted a resolution establishing a permanent liaison committee with the Department of Social Services re Medicaid. This Committee is to reflect doctors who have significant practice with Medicaid patients and experience in billing for Medicaid services. Members of the new committee are Doctor Fryfogle, Doctor Siegel, and Doctor Toteff from the original liaison committee; and, Richard Cecconi, MD, Iron Mountain; Thomas Flake, MD, Detroit; John Loomis, MD, River Rouge; Marion McCall, MD, Detroit; Robert E. Rice, MD, Greenville, and James Johnston, MD, Traverse City.

This Committee met with R. Bernard Houston, Director, Department of Social Services and Stuart Paterson, Deputy Director, Department of Social Services for Medicaid, August 29. Some tentative agreements were approached on a number of issues and a series of meetings through the coming 12 months were established.

Next meeting between the Liaison Committee and the Department will be Wednesday, Nov. 14, 1973, in Lansing.

Committee on Medical Socio-Economics

Dale L. Kessler, MD, *Chairman*

The Committee continued its investigation of current mechanisms used by the various health insurers to reimburse physicians. Meetings were held with Michigan Blue Shield and progress has been made in refining the following three aspects of the Blue Shield UCR reimbursement:

1. *The Entry Level Profile of a New Doctor.* Blue Shield has established guidelines to determine beginning profiles for new doctors that are fair to doctors who have established charge histories.

2. *Immediate Area Adjacent Problem.* Blue Shield is studying current prevailing area boundaries that divide medical service areas and refinements are expected.

3. *Limitations on Permitted Fee Increases for Doctors who Request Fee Increases on an Infrequent Basis.* Blue Shield has implemented provisions which enable doctors who do not update their profiles on a regular basis to do so without being penalized.

The Committee plans to continue its investigations and will report its progress to The Council on a regular basis.

Committee on Mental Health

Benjamin Jeffries, MD, *Chairman*

The Committee met on March 21 and March 25, 1973.

A major concern of the Committee centered on the controversy which arose during the year regarding a Lafayette Clinic research procedure. The procedure used depth electroencephalography to determine the presence of a brain lesion and evidence that the lesion produced uncontrollable impulses triggering violent aggression. A suit was instituted in Wayne County Circuit Court by the Medical Committee on Human Rights in behalf of an Ionia State Hospital patient against the Lafayette Clinic and the State Department of Mental Health to halt the project by arguing that this individual could not give informed legal consent and that therefore the brain operation was illegal in Michigan. The project was halted and the Court determined that the procedures under which the inmate was sent to Ionia and kept there violated his constitutional rights. The Court reached no definitive decision on whether an adult, involuntarily confined to a state mental hospital, can give informed consent or whether experimental brain surgery was legal in Michigan.

The issue remains open and has become the subject of proposals in the Michigan Legislature. The Committee believes that a prohibition against these procedures would eventually restrict physicians from doing exploratory research and seriously hinder medical research and subsequent therapy in every field. The Committee, after approval by The Council, issued a position paper on the matter.

The Committee also considered the importance of protecting the confidentiality and privacy of patient records, particularly in view of a proposed data collection system of the Department of Mental Health. The Committee recommended that MSMS support legislation prohibiting any state agency from gathering or storing information about diagnosis or treatment for mental, emotional or physical disorders from which the identity of the patient can be determined.

A request was made of The Council to authorize a change in the Committee's composition by adding representatives of non-psychiatry specialties. The Council suggested that no formal change be made, but that the Committee invite such specialities to the meeting when matters of mutual concern are scheduled for discussion.

Committee on Occupational Health

Duane L. Block, MD, *Chairman*

The Committee is continuing its study of the impact that the Occupational Safety and Health Act of 1970 will have on the practice of medicine. This legislation imposes responsibilities on the physician both as an employer and as a provider of services in the field of occupational health.

The American Medical Association has prepared an excellent analysis of this Act for the benefit of physicians and at the request of the Committee, an announcement was published in *Medigram* urging MSMS members to request a copy of the AMA Analysis.

Committee on Professional Insurance Plans

Justin L. Sleight, MD, *Chairman*

The Committee has continued its efforts to strengthen and broaden group insurance programs for MSMS members.

1. *Blue Cross/Blue Shield Economy Program.* The Blue Cross/Blue Shield Econo-plan is now available on an individual optional basis in lieu of MVF-2 for MSMS members participating in the MSMS 94000 Blue Cross/Blue Shield group. Blue Cross benefits under the econo-plan are subject to a 30 percent co-payment up to a maximum of $600 for each inpatient admission, but this co-payment requirement does not apply to hospital outpatient care. Blue Shield benefits are subject also to a 30 percent co-payment feature without any limitation to the amount of subscriber liability. Some of the benefits found under MVF-2, such as coverage for immediate maternity, outpatient psychiatric and convalescent care, and full payments for diagnostic X-ray and laboratory services, are not benefits of the econo-plan program. A subscriber physician electing the econo-plan rather than the MVF-2 plan would save approximately $29 per month on a full family contract ($76 vs $47).

2. *Blue Cross/Blue Shield Coverage for Widows of MSMS Members.* Effective Aug. 1, 1973, the MSMS 94000 Blue Cross/Blue Shield Group was opened to widows of MSMS members. Arrangements have been made so that past widows of the last five years as well as future widows will be notified of the availability of these benefits.

3. *Disability Insurance.* The MSMS disability insurance program has been broadened to offer interns and residents, under age 34, who become associate members of the MSMS, disability insurance at a very low cost. Specifically, $325 monthly indemnity on a Lifetime Accident-Five-Year Sickness Plan with benefits commencing first day for accident and sixteenth day for sickness is available at an annual premium of $10. This new offering assisted county medical societies membership campaigns to enroll younger physicians.

4. *Life Insurance Open Enrollment.* An open enrollment for the life insurance program was conducted in February and March. Over 500 new applications were received and these new participants will add additional strength to this highly successful program.

5. *Assignment of Interest Under MSMS Group Life Insurance Master Contract.* The MSMS Group Life Insurance Program has been improved by amending the master contract between MSMS and the Mutual Benefit Life Insurance Company to allow the participant to assign his interest under the contract to the spouse, child, parent, brother or sister of the person insured, or to a trust established for the benefit of one of the above mentioned.

Committee on Public and Environmental Health

Louis R. Zako, MD, *Chairman*

The Committee met on Nov. 29, 1972, and Feb. 7, 1973. Meetings of its subcommittees were also held, along with a Detroit Conference on the Physician and Environmental Quality Control on Nov. 9-10. The Conference was the third such meeting of representatives from Canada and the states bordering on the Great Lakes. The committee will continue its work in following through on the recommendations made at the Conference.

The Committee cooperated with the MSMS Communications Department and the Michigan Jaycees in conducting a venereal disease awareness program.

Michigan hospitals were notified of the Committee's stand on use of disposable items and smoking in patients' rooms, smoking by staff members, and the selling of cigarettes in hospitals. A significant number of hospitals responded to the letter, indicating their intention to cooperate.

The Committee continued its liaison with the Michigan Department of Public Health and the Michigan Lung Association.

Other matters discussed by the Committee were: transfusion reactions, mass X-ray service, nuclear power plants in Michigan, the transfer and consolidation of environmental functions within the Department of Natural Resources, and asymtomatic gonorrhea. The Committee's recommendation to The Council on gonorrhea testing was approved and all members were urged to give gonorrhea detection tests to their women patients. This program received widespread radio and newspaper coverage.

Committee on Public Relations

Thomas C. Payne, MD, *Chairman*

This Committee met Nov. 2, 1972, and May 10, 1973 and several task forces met during the year to advise the MSMS Department of Communications on aspects of the five-point program of the Committee.

1. *Five-Point MSMS Public Relations Program.* The Committee is implementing the five subjects chosen at the May 24, 1972 meeting for major emphasis during 1973.

This report will summarize some of the efforts in each area:

A. *Help improve communications with medical assistants:* A task force of medical assistants and members of the PR Committee met and decided that the matter of good telephone techniques was of utmost importance from a public relations standpoint. The task force developed an original script so that good and bad examples of telephone manners of the medical assistant could be demonstrated. As a pilot project, members of the Ingham County Medical Society were invited to send a medical assistant to a workshop on telephone techniques at MSMS April 3. The maximum of 30 registrants was surpassed and a second workshop was held May 22. The medical assistants and physicians present who helped conduct the workshop felt the project was very successful. A mailing was made to all component medical societies explaining this new project and urging each to conduct such a program during 1973-74 for the medical assistants. The script was also used during the summer at the leadership workshop of the state chapter of the American Association of Medical Assistants and again local workshops were advocated.

B. *Help inform the profession and public about chiropractic.* The plan of work of the Committee was incorporated into a resolution that was introduced at the 1973 spring meeting of the MSMS House of Delegates by Richard Gascoigne, MD, who had been appointed by The MSMS Council as a special MSMS liaison with governmental agencies re chiropractic. The resolution was adopted and gives direction to the Public Relations Committee's subcommittee re chiropractic, which is chaired by Doctor Gascoigne. The Committee wrote each component society and asked that they designate one physician to serve on the MSMS task force. Those representatives met with the members of the PR Committee and the Legal Affairs Committee for a special workshop on chiropractic May 10 at MSMS. Joseph Sabatier, MD, of New Orleans, chairman of the AMA Committee on Quackery, was the featured speaker. A special feature section about chiropractic appeared in the July issue of *Michigan Medicine* as one of the Committee's attempts to inform the profession. Copies of chiropractic newspaper ads that are felt to be misleading are being sent periodically to the MSMS Legal Counsel and to the Michigan Press Association for review.

C. *Continue to provide information about VD.* Leaders of the MSMS Committee on Public and Environmental Health and the MSMS PR Committee have met several times with officials of the Michigan Jaycees to facilitate a joint VD educational effort. A letter was sent to all components urging that they work locally with the Jaycees to reach school children, youth groups, etc. Several news releases have been issued throughout the year.

D. *Provide information about the health aspects of pollution.* The PR Committee assisted in the promotion of and interpretation of the "Great Lakes Conference on the Physician and Environmental Quality Control," sponsored by the MSMS Committee on Public and Environmental Health, in Detroit, Nov. 9-10, 1972.

E. *Help people get a doctor.* The Committee has identified 23 different projects that MSMS can carry on in this area. The following comments cannot be complete, but brief comments will show the extensive nature of the thrust. MSMS has conferred with MARMP about the possible funding of a statewide survey of MD needs. MSMS has held three meetings with selected foreign-trained physicians to further improve their service to Michigan residents. MSMS worked effectively to amend a state law to permit a physician trained in Indiana to get reciprocity and thus begin his practice in Zeeland. MSMS has asked component societies regarding their manpower needs and MSMS has an ad hoc committee meeting with Michigan Health Council representatives to further improve the operation of MD placement machinery in Michigan. MSMS co-sponsored a Conference on Rural Health to bring together rural Michigan physicians and rural community leaders to explore MD needs. The Woman's Auxiliary has an effective Telstar project to help new residents find physicians. MSMS ran a feature on MD training and supply in the January issue of *Michigan Medicine* and sent a copy with an appropriate cover letter to each Michigan legislator urging their continued support to expand the three medical schools further. Work will be concentrated on this PR project in 1973-74.

2. *Smoking-Health Guide for Teachers.* In 1971-72, the PR Committee carried out a multi-pronged attack on the problems of smoking and health. The need for a teacher's curriculum guide was identified and a health educator at Central Michigan University agreed to update an earlier version published by the Michigan Health Council. The Michigan Department of Education assured MSMS of the need for such a booklet, and The MSMS Council this spring authorized a special grant to publish and distribute a guide to Michigan teachers. The job was expected from the printer in September and distribution was planned to follow immediately.

3. *MSMS-WUOM Radio Series.* This series of weekly radio tapes, produced and mailed by WUOM, was carried out throughout the year to feature chairmen of MSMS committees, medical educators and physicians with special knowledge in various areas. The 15 minute programs soon will be cut to 5 minutes and will be sent to more stations. The stations, it is hoped, will carry the 5 minute tape several times during the day and during the week.

4. *MSMS Medical Memo.* As a new effort to provide information to MSMS members and to permit them to ask questions and seek help, MSMS in May began a two-month pilot taped news report over a special 800 telephone number. There was an average of about 10 calls a day during the summer and The Council in August authorized continuation of the project through November. The Committee feels this is another way to provide quick information to doctors about actions taken by The MSMS Council, and to ask doctors to help carry out MSMS efforts to communicate with the patients and selected public. This project, the only one of its kind by any state medical society, is being evaluated carefully to measure its value and potential.

5. *MSMS Slide Series.* The Committee advised the MSMS Communications Department on the development of a series of 2 x 2 colored slides with a prepared script about MSMS operations. The slides were shown at the spring meeting of the MSMS House of Delegates and several component societies. MSMS Councilors will offer this slide program to component societies during 1973-74.

The Committee wishes to thank the Woman's Auxiliary and the Medical Assistants for appointing two advisors to the parent committee and for naming representatives to several task forces. The Chairman feels that much can be accomplished through the joint efforts of the three organizations.

Committee on Rural Medical Services

Donald R. McCorvie, MD, *Chairman*

The Committee met on Feb. 21, 1973. The Chairman gave a progress report on final plans for the May, 1973 Conference on Rural Health jointly sponsored with the Michigan Health Council and Michigan State University.

Doctor McCorvie served as Conference General Chairman during the Conference and several members of the Committee attended.

Representatives of the AMA Council on Rural Health, the Michigan Health Council, the MSMS Committee and other interested individuals met on May 24, 1973 to discuss plans and activities at the AMA's 27th National Conference on Rural Health in Detroit in April, 1974.

Committee on Utilization Review & Health Insurance Problems

Robert C. Prophater, MD, *Chairman*

The Committee acting as an appeal body in the MSMS peer review structure considered several utilization and fee matters on appeal from county medical societies.

The "Guidelines for MSMS Peer Review Program" have been modified so that in the future the regional medical advisory committees will be invited to present testimony on the case under appeal.

Meetings were held with Michigan Blue Shield to consider several matters assigned to the Committee from The Council for study and solution including: 1) division of global surgical fee, 2) developing a new "Doctor's Service Report" form that is more acceptable to Michigan physicians, and 3) adding elective sterilization to existing Blue Shield benefits. Regular reports on the progress that the Committee is making in resolving these problems has been transmitted to The Council.

The Committee conferred with representatives of the Aetna Insurance Company regarding the various types of health insurance contracts underwritten by Aetna and the methodology used to determine prevailing fees for physician reimbursement. Similar meetings are being planned with other commercial health insurance companies.

17. Reports of House of Delegates Committees

Committee on Certificates of Commendation

George D. Stilwill, MD, *Chairman*

The MSMS House of Delegates in 1961 established the MSMS Certificates of Commendation. The original action instructed that the awards "may include both scientific and/or public service, and may be awarded to one or several physicians annually who distinguish themselves in the medical profession."

The 1962 House of Delegates presented the first four such awards, and a number of awards have been recommended each year by committee and approved by the delegates.

This year, the Committee invited each component medical society to submit nominations. The Committee carefully evaluated ten physicians who had been nominated. The selection was most difficult.

The Committee is proud this year to present the names of five outstanding Michigan physicians for Certificates of Commendation. They are:

William G. Birch, MD, of Kalamazoo
James F. Dooley, MD, of Flint
Jacques S. Gottlieb, MD, of Detroit
Arthur W. Strom, MD, of Hillsdale
Robert K. Whiteley, MD, of Detroit

Here are short biographies for your review:

WILLIAM G. BIRCH, MD

William G. Birch, MD, an obstetrician and gynecologist from Kalamazoo, was instrumental in the development of the Type A, Physician Assistant Program at Western Michigan University. He was born July 8, 1909, in Janesville, Wis. He spent his pre-medical school years at the University of Iowa and received his medical degree from Northwestern University. He interned at Chicago Maternity Center and Chicago Lying-In, remaining at Lying-In for his residency. Doctor Birch co-founded the Sault Polyclinic in Sault Ste. Marie before moving to Kalamazoo in 1945. As a delegate from the Kalamazoo Academy of Medicine in 1965, he introduced a resolution that was adopted by the MSMS House of Delegates to begin feasibility studies into the possible training for physician's assistants in Michigan. He then explored the program possibilities with the Kalamazoo Academy, local hospitals and Western Michigan University. He serves as chairman of the MSMS Education Liaison Committee Subcommittee on the Physician Assistant Program. He is clinical director of the PA program at Western. Doctor Birch has been active in the Rotary Club, the Kalamazoo Symphony Orchestra, the Executive Club, served as Vestryman in his church, and taught classes at WMU and Bronson Hospital. He is a former president of the Kalamazoo Academy of Medicine and the South Central Michigan Planning Council. He is a member of the Michigan Society of Obstetricians and Gynecologists, also a Fellow of the American College of Obstetricians and Gynecologists and a Diplomate of the American Board of Obstetricians and Gynecologists.

JAMES F. DOOLEY, MD

Through the efforts of James F. Dooley, MD, of Flint, the three medical schools in Michigan now have Family Practice Clubs. Doctor Dooley, a family practitioner, was born in Cincinnati on June 10, 1925. He received his BS from the University of Dayton, his MD degree from the University of Cincinnati, and served his internship and residency at St. Joseph Hospital in Flint. He now is chief of the St. Joseph Hospital Department of Emergency Service and a member of the Executive Committee. He also is affiliated with Hurley Hospital and McLaren General in that city. Doctor Dooley has made many contributions to numerous medical organizations and the community. He has served as president and secretary of both the Genesee County Medical Society and the Genesee County Academy of General Practice. He is a past president of the Michigan Academy of General Practice, and is an alternate delegate to the American Academy of General Practice Congress of Delegates. He has been a member of numerous committees on the county, state, and national level. It was during his term as chairman of the Michigan Academy of General Practice's Education Commission that he initiated the establishment of the Family Practice Clubs. He is a founding member of the Flint Institute of Arts and a member of the planning committee of the Genesee-Lapeer-Shiawassee Comprehensive Health Planning Council.

JACQUES S. GOTTLIEB, MD

Doctor Jacques S. Gottlieb's research in the field of schizophrenia won him the Gold Medal for Distinguished Research by the Society of Biological Psychiatry. Doctor Gottlieb was born in Trinidad, Colo., Feb. 2, 1907, and is a graduate of Harvard University and the Harvard University Medical School. He was associated with Worcester Hahnemann Hospital, Montefiore Hospital of New York, Worcester State Hospital, Psychopathic Hospital of Iowa City, and Jackson Memorial Hospital in Miami before becoming director of Detroit's Lafayette Clinic in 1955. It has been during his years at Lafayette that Doctor Gottlieb has done his world-renowned research into a biologic mechanism in schizophrenia. Doctor Gottlieb holds membership in seventeen national, state, and county medical organizations. He recently retired as chairman of the Department of Psychiatry at Wayne State University School of Medicine. He is president of the Society of Biological Psychiatry. He has been named recipient of the 1973 Taylor Manor Hospital Psychiatric Award and, in 1972, the Michigan Legislature paid tribute to Doctor Gottlieb by adopted House Concurrent Resolution No. 577 commending him for his "lifetime of devoted labor in the fields of medical research and medical education."

ARTHUR W. STROM, MD

For more than a generation Doctor Arthur W. Strom has served Hillsdale County medical community. Born June 18, 1908 in Buffalo, N.Y., Doctor Strom attended Cornell University before beginning his medical school training at the University of Buffalo (now the State University of New York at Buffalo). After serving his internship and residency in internal medicine at Henry Ford Hospital, Doctor Strom began his practice in Hillsdale, where he has served 38 years. In 1950, Doctor Strom, with the late Doctor Frank Rector, developed the Hillsdale Tumor Detection Plan which won his county medical society special recognition from the Michigan State Medical Society. Later, under his direction, a Coronary Care Unit was established in Hillsdale. Doctor Strom served as president of the Michigan Society of Internal Medicine and twice as president of the Hillsdale County Medical Society. He has been a trustee and second vice president of the Michigan Tuberculosis and Respiratory Disease Association, a trustee and consultant to the Commission on Professional and Hospital Activity. He was president of the Hillsdale Community School Board on two occasions. A long-time delegate to the Michigan State Medical Society House of Delegates, Doctor Strom presently is chief of medicine at the Hillsdale Community Health Center.

ROBERT K. WHITELEY, MD

Robert K. Whiteley, MD, of Detroit, has been active in civic affairs and has fulfilled leadership roles with the Wayne County Medical Society and Michigan State Medical Society. Born on Jan. 7, 1909 in Warren, Ariz., Doctor Whiteley received his medical degree from the University of Michigan in 1933, and served his internship and residency in obstetrics and gynecology at Detroit's Harper Hospital. While serving in the South Pacific during World War II, he was captured at Bataan and spent the rest of the war years in a prison camp, Camp Davao. While there, he and other doctors held captive provided what medical care they could with the limited surgical instruments and supplies made available to them, saving many lives. Doctor Whiteley has served as secretary and president of the Wayne County Medical Society, as a delegate to the MSMS House of Delegates. During his term as an MSMS Councilor, he was chairman of the MSMS Finance Committee. He was president of the Grosse Pte. Board of Education and a member for many years, a trustee of the Detroit Institute of Technology, and director of Frank C. Teal Electric Company. Doctor Whiteley is presently on the staff of Harper, Jennings Memorial and Bon Secours Hospitals.

MSMS Certificates of Commendation have been presented by the MSMS House of Delegates to the following distinguished physicians since the award was originated in 1961:

1962 J. W. Conn, MD, Ann Arbor
G. D. Cummings, MD, Lansing
C. S. Kennedy, MD, Detroit
R. L. Novy, MD, Detroit

1963 F. D. Dodrell, MD, Bloomfield Hills
C. J. Jentgen, MD, Detroit
J. M. Sheldon, MD, Ann Arbor
H. H. Stryker, MD, Kalamazoo

1964 Goldie Corneliuson, MD, Lansing
J. S. DeTar, MD, Milan
R. M. Heavenrich, MD, Saginaw
N. F. Miller, MD, Ann Arbor
E. G. Upjohn, MD, Kalamazoo
O. R. Yoder, MD, Ypsilanti

1965 F. J. Hodges, MD, Ann Arbor
T. Leucutia, MD, Detroit
R. J. Robinson, MD, Detroit

1966 A. C. Curtis, MD, Ann Arbor
L. L. Davis, MD, Mt. Pleasant
Mark Marshall, MD, Ann Arbor
H. J. Meier, MD, Coldwater
R. H. Pino, MD, Detroit
A. B. Swanson, MD, Grand Rapids
H. A. Towsley, MD, Ann Arbor

1967 F. J. Busch, MD, Saginaw
W. H. Huron, MD, Iron Mountain
F. J. Margolis, MD, Kalamazoo
D. I. Sugar, MD, Detroit (posthumously)
R. W. Waggoner, MD, Ann Arbor
C. H. Wright, MD, Detroit

1968 A. F. Barbour, MD, Flint
H. L. Clark, MD, Ludington
J. M. Dorsey, MD, Detroit
F. C. Sabin, MD, Marquette
W. D. Towsley, MD, Midland

1969 H. A. Furlong, MD, Pontiac
W. W. Jack, MD, Grand Rapids
A. C. Kerlikowske, MD, Ann Arbor
R. C. Prophater, MD, Bay City
A. L. Tuuri, MD, Flint
C. M. Vasu, MD, Grand Rapids

1970 H. E. Branch, MD, Flint
M. Clapper, MD, Detroit
H. F. Falls, MD, Ann Arbor
H. W. Harris, MD, Lansing
R. E. Rice, MD, Greenville
Sarah Schooten, MD, Detroit

1971 E. R. Elzinga, MD, Marquette
T. N. Evans, MD, Detroit
J. V. Fopeano, MD, Kalamazoo
L. E. Holly, Sr., MD, Muskegon
J. M. Kennary, Sr., MD, Detroit
L. F. Swan, MD, Detroit

1972 L. G. Bateman, MD, Flint
Dean C. Burns, MD, Petoskey
Elisha S. Gurdjian, MD, Detroit
R. M. Nalbandian, MD, Grand Rapids
A. L. Stanley, MD, Lansing

THE HOUSE, acting as a committee of the whole, approved the report of the Committee. Subsequently, at the Monday evening Installation Dinner, Certificates of Commendation were presented to Doctors Birch, Dooley, Gottlieb, Strom and Whiteley.

Committee on Constitution and Bylaws

PART I (edited for printing)

The following proposed Bylaws changes were adopted on first reading by the Spring 1973 House of Delegates and are herewith presented for final consideration:

1. *Section on Clinical Pharmacology and Therapeutics*

PROPOSED AMENDMENT: That Chapter 14, Sec. 1, of the MSMS Bylaws, be amended by adding to the list of sections "Clinical Pharmacology and Therapeutics."

THE REFERENCE COMMITTEE on Constitution and Bylaws, Lee B. Stevenson, MD, Chairman, recommended adoption of the Bylaws amendment to add a Section on Clinical Pharmacology and Therapeutics, as contained in Item 1.

THE HOUSE postponed action on the establishment of a Section on Clinical Pharmacology and Therapeutics pending further information.

2. *Separate Gratiot and Isabella-Clare County Medical Societies*

PROPOSED AMENDMENT:

(1) That Chapter 10, Sec. 9, be amended to change listing for the Eighth District as follows: "~~Gratiot-Isabella-Clare~~, GRATIOT, ISABELLA-CLARE, Midland, Saginaw, Tuscola."

(2) That Chapter 11, Sec. 2, be amended to change listing for District #4 as follows: "Bay-Arenac-Iosco, Genesee, Gratiot-~~Isabella-Clare~~, Huron, ISABELLA-CLARE, Lapeer, Midland, Saginaw, Sanilac, Tuscola."

3. *Revisions in Chapter 11—Judicial Commission*

PROPOSED AMENDMENT:

(1) Amend Constitution, Article XI—JUDICIAL COMMISSION, second sentence, as follows: "It shall consist of members to be elected by the voting members of the Society, ~~provided, however, that the members of the first Judicial Commission established hereunder shall be selected in such manner as may be provided by the Bylaws to serve until their respective successors are elected~~."

(2) Amend Bylaws Chapter 11, Sec. 3, as follows: "Sec. 3. NOMINATIONS—On or before ~~September 25 in the year 1965 and on or before~~ July 15th ~~in~~ each ~~succeeding~~ year, the chairman of The Council shall, with the advice and consent of The Council, appoint a Nominating Committee composed of seven members of The Council. Such Nominating Committee shall select from the voting members in good standing of the Society in each Judicial District at least twice as many nominees for the office of Judicial Commissioner as are to be elected in such year from such district. After obtaining the consent of such nominees to become candidates, the Nominating Committee shall submit its list of nominations to the secretary of the Society on ~~or before October 15 in the year 1965 and~~ on or before September ~~1st in each succeeding year~~. Within ten days thereafter, the secretary of the Society shall post a list of such nominations in a conspicuous place in the headquarters building of the Society and shall mail a list of such nominations to the secretary of each said component ~~county~~ society and shall give notice to the secretary of each said component ~~county~~ society that the voting members of this Society within the several Judicial Districts have the right to make additional nominations by petition as hereinafter set forth. Promptly upon receipt of such notice and list of nominations the secretary of each component ~~county~~ society shall make such nominations known to the voting members thereof in such manner as shall be determined by the component ~~county~~ society. Additional nominations may be made by petition signed by not less than twenty-five voting members in good standing in any Judicial District. Such nominating petitions shall be filed with the secretary of this Society ~~not later than November 25th in the year 1065~~ and not later than Oct. 15th ~~in each succeeding year~~.

(3) Amend Chapter 11, Sec. 4, as follows: Sec. 4. BALLOT-ELECTION—Under the direction of the secretary of the Society, separate ballots, in such form as shall not identify the voter, shall be prepared for each Judicial District from which a member of the Commission is to be elected. On or before ~~December 15 in the year 1965 and on or before~~ November 10th ~~in~~ each ~~succeeding~~ year in which a member of the Commission is to be elected from such district, the Secretary of the society shall mail a ballot containing the names of all nominees, arranged in alphabetical order, to each voting member in good standing of the Society in such Judicial District. Ballots shall be marked and returned to the office of the Society ~~not later than December 30th in the year 1965~~ and not later than December 1st ~~in~~ each ~~succeeding~~ year and any ballot bearing postmark later than such date shall not be counted. Each ballot, to be valid, must be voted for neither a greater nor a smaller number of nominees than are to be elected from such district at such election. The ballot furnished to voting members shall have printed upon it a copy of the last preceding sentence.

The valid ballots so cast shall be tabulated and the results certified by ~~an independent service agency under the supervision~~ of the Secretary of the Society. In case of a tie vote, the winning candidate shall be determined by lot under the supervision of the Secretary. Those elected shall be notified by the Secretary and the names of those elected shall be made known to the members of the Society through publication in the Journal of the Society or by such other means as shall be directed by The Council.

4. *Component Society Constitutions and Bylaws on File at Headquarters*

PROPOSED AMENDMENT:

Amend Chapter 1, Sec. 1, as follows: Sec. 1. CHARTER—The charter of each component county society shall be authorized by the House of Delegates and signed by the president and secretary. Such charter shall require that the constitution and bylaws of such component county society shall be at all times consistent with the provisions of the Constitution and Bylaws of this Society and with all amendments thereto hereafter adopted. EACH COMPONENT COUNTY SOCIETY SHALL FILE WITH THE STATE SOCIETY HEADQUARTERS A CURRENT COPY OF ITS CONSTITUION AND BYLAWS.

5. *Deletion of Provisions for Quarterly Payment of Dues*

PROPOSED AMENDMENT:

(1) Amend Chapter 4, Sec. 1. CHANGE OF LOCATION—PROCEDURE, first sentence, as follows: When a member of a component county society, by reason of a change of location, desires to transfer his membership to another component county society, he shall make application thereto accompanied by tender of dues for the remaining ~~quarter~~ HALF of the current year (any major fraction of a ~~quarter~~ HALF being regarded as a full ~~quarter~~ HALF and any minor fraction being disregarded.)

(2) Amend Chapter 4, Sec. 1 (c), as follows: (c) Component county society dues and assessments shall have been paid to cover that portion of the year in which application for transfer is made (any major fraction of a ~~quarter~~ HALF year being regarded as a full ~~quarter~~ HALF and any minor fraction being disregarded.)

(3) Amend Chapter 4, Sec. 2, as follows: Sec. 2. REFUND OF DUES—When a member shall have transferred to another component county society in accordance with the provisions of Sec. 1 above, he shall be entitled to a refund, from the Society from which he has transferred, of prepaid dues to such society (any major fraction of a ~~quarter~~ HALF year being regarded as a full ~~quarter~~ HALF and any minor fraction being disregarded.)

(4) Amend Chapter 4, Sec. 3, second paragraph, as follows: If the resigning member shall have prepaid dues to this Society or to his component county society for any period beyond the ~~quarter~~ HALF year in which his resignation becomes effective, such excess shall be refunded to him by the respective Societies.

(5) Amend Chapter 5, Sec. 3. NEW MEMBERS, first two sentences, as follows: For the purpose of determining the dues for new members only, the fiscal year of this Society shall be divided into ~~four three-month~~ TWO SIX-MONTH periods. New members shall pay adjusted annual dues and assessments for the unexpired ~~quarterly~~ SEMI-ANNUAL periods of that year.

6. *Change in Dues Reduction for First Year of Practice*

PROPOSED AMENDMENT:

Amend Chapter 5, Sec. 4, as follows: Sec. 4. FIRST YEAR OF PRACTICE—The annual dues payable to this Society by a doctor of medicine who, by reason of his being elected to membership during his first year of practice, is granted a reduction of dues by his component ~~county~~ society, or if such component ~~county~~ society exacts no dues, shall be ~~one third~~ ONE-HALF of the established amount during his first year of practice and ~~one half of the established amount during his second year of practice~~. this reduction in annual dues shall not exempt such member from the payment of any regularly levied assessment.

7. *Seating of Delegates and Alternates*

PROPOSED AMENDMENT:

(1) Amend Chapter 9, Sec. 4, as follows: Sec. 4. SEATING-TENURE—A delegate, ~~or in his absence, an alternate delegate (in order of seniority)~~ becomes a member of the House of Delegates when ~~duly registered and seated at the first scheduled regular session following certification~~ THE SPEAKER IS NOTIFIED OF HIS ELECTION, IN WRITING, BY THE SECRETARY OF HIS ~~the~~ component society, specialty section or SAMA chapter, ~~and remains a delegate until the expiration of his term~~. SUCH CERTIFICATION SHALL BE SUBMITTED BY FEB. 1 OF EACH YEAR. THE DELEGATE SHALL REMAIN A MEMBER OF THE HOUSE OF DELEGATES UNTIL THE SPEAKER IS NOTIFIED IN WRITING BY THE SECRETARY OF THE COMPONENT SOCIETY, SPECIALTY SECTION OR SAMA CHAPTER THAT THE DELEGATE HAS BEEN REPLACED. THE DELEGATE SHALL REMAIN A MEMBER OF THE HOUSE OF DELEGATES FOR HIS FULL TERM REGARDLESS OF WHETHER OR NOT AN ALTERNATE SUBSTITUTES FOR HIM AT ANY MEETING OF THE HOUSE.

(2) Add new Chapter 9, Sec. 5, as follows, and appropriately renumber subsequent sections: Sec. 5. SEATING OF ALTERNATE DELEGATES—An alternate delegate (in order of seniority) may substitute for a duly certified delegate at any regular or special meeting of the House of Delegates provided that such substitution is authorized in writing by the secretary of the component society, specialty section or SAMA chapter.

8. *Councilors as Voting Members of the House of Delegates*

PROPOSED AMENDMENT:

Amend Chapter 9, Sec. 2, by adding the following sentence: Except for the speaker, vice-speaker and immediate past president, members of The Council are not eligible for election as delegates by their component societies.

9. *Medical School Deans as Members of the House of Delegates*

PROPOSED AMENDMENT:

Amend Chapter 9, Sec. 2, by adding the following paragraph: The dean of each accredited medical school in Michigan, if he is an active member of MSMS, shall be a delegate-at-large to the House of Delegates, with voting priviliges. An alternate may not be seated for him, and any provisions of these Bylaws regarding the seating of an alternate shall not apply.

10. *Change of Section Name*

PROPOSED AMENDMENT:

Amend Chapter 14, Sec. 1, by deleting the words "General Practice" and adding the words "Family and General Practice" to the list of sections.

11. *Change in Provisions re Notice of Hearings in Disciplinary Cases*

PROPOSED AMENDMENT:

Amend Chapter 6, Sec. 10 to read: A written notice of such hearing, together with a copy of the formal complaint shall be served on the respondent by registered or certified mail, OR OTHER APPROPRIATE MEANS AS APPROVED BY THE MSMS JUDICIAL COMMISSION, not less than 30 days before the date of such hearing.

THE REFERENCE COMMITTEE recommended final adoption of the Bylaws amendments as contained in Items 2 through 11.

THE HOUSE adopted the foregoing amendments on final reading.

PART II

The following amendments are presented on first reading for consideration by the House of Delegates:

1. *MSMS Purposes*

PROPOSED AMENDMENT:

Amend Article II of the Constitution to read: Sec. 1.—PURPOSES—The purposes of this Society shall be: To bring into one viable, effective organization the ethical physicians licensed to practice in Michigan in order that their contribution to human welfare will be enhanced.

In order to accomplish this effectively, the Society also will work to accomplish the following sub-purposes:

A. To constitute, support and advise the American Medical Association in cooperation with similar societies of other states, in meeting its appropriate responsibilities.

B. To charter and organize constituent component medical societies.

C. To conceive, develop and administer health education programs designed to improve public understanding, awareness and acceptance of good medical standards, practices and concepts, as they relate to personal health, scientific progress and society's advancement.

D. To stimulate advancement of the science and art of medicine and continually to seek to advance the medical, scientific, social, environmental, economic and medical political knowledge of its members in order that the doctor may better serve his patients and the public health generally.

E. To aid Michigan physicians individually and collectively in maintaining high levels of ethical conduct and standards of practice to protect and serve the total public.

F. To provide medical leadership in meeting the health needs of the people by working with other medical and nonmedical groups and individuals.

G. To preserve, protect and enhance physician-patient relationships, as basic to the delivery of quality health care.

H. To promote quality medical and health care by development and support of activities appropriate to this goal.

I. To advocate fair remuneration for services rendered.

J. To ensure the adequacy of medical manpower by attracting capable people into the medical and health professions and to work toward the most effective distribution of their services.

K. To encourage medical students and physicians-in-training to participate in organized medicine in order to enable MSMS to be representative of all physicians.

L. To support the efforts of those who would preserve, protect and enhance the reputation and services of the medical profession.

M. To institute and provide specific services to meet the needs of the members.

N. To foster and support continuing medical education.

COMMENT: These Purposes, as presented by the MSMS Committee on Planning and Priorities, were amended and adopted by the Spring 1973 House of Delegates. However, since Constitutional amendments can only be presented at *Annual* Meetings of the House of Delegates, this amendment is now being presented on first reading.

RECOMMENDATION: That this Constitutional amendment be adopted on first reading.

2. *Deletion of Article VIII of the Constitution*

PROPOSED AMENDMENT:

That this article be deleted from the Constitution and subsequently articles be appropriately renumbered.

COMMENT: This article lists various classifications of members within the society and appears to be unnecessary since it is repetitious of the Bylaws. If it is not deleted, it would be necessary to revise the list of classifications to agree with the Bylaws.

RECOMMENDATION: That this Constitutional amendment be adopted on first reading.

3. *Revision of Sec. 1, Article XIII of the Constitution*

PROPOSED AMENDMENT:

Amend this article as follows: Sec. 1—METHOD OF AMENDMENT—The House of Delegates may amend any article of this Constitution by a two-thirds vote of the Delegates seated at any ~~Annual~~ REGULAR Session, provided that such amendment shall have been presented in open meeting at the previous ~~Annual~~ REGULAR Session, and that it shall have been published at least once during the ~~year~~ INTERVAL in the Journal of the Society, or sent officially to each component county society at least two months before the meeting at which final action is to be taken.

COMMENT: This amendment is recommended so that matter requiring both Constitutional and Bylaws amendments can be acted on at regular sessions other than the Annual Meeting, in the event there is more than one regular House meeting in one year.

RECOMMENDATION: That this Constitutional amendment be adopted on first reading.

THE REFERENCE COMMITTEE recommended adoption of the Bylaws amendments as contained in Items 1, 2 and 3.

THE HOUSE approved on first reading the foregoing amendments. (In accordance with Bylaws provisions, they will be laid over to the next session for final reading.)

4. *Proposed Revision of Chapter 2—Membership Classifications*

At the Spring 1973 House of Delegates, this proposed revision was returned to the Committee for further study.

PROPOSED AMENDMENT:

That Chapter 2 of the MSMS Bylaws be revised to read as follows, and that Sections 8 and 9 of Chapter 5 be deleted: CHAPTER 2—MEMBERSHIP—CLASSIFICATION—ELECTION—

Sec. 1. DEFINITION—As used in these Bylaws, except as otherwise herein expressly qualified, whenever the terms "doctor of medicine" or "practice of medicine" or "medical profession" are used, these terms shall be deemed to include the terms "doctor of medicine and doctor of osteopathy," "practice of medicine and practice of osteopathy," and "medical profession and osteopathic profession."

Sec. 2. MEMBERSHIP PREREQUISITE—All members of the several component societies, when in good standing, are thereby and must be members of this Society.

Sec. 3. ACTIVE MEMBERS—To be eligible for active membership in any component society, a doctor of medicine must hold an unrevoked permanent license in Michigan or, if unlicensed, must be engaged in academic teaching, research or administration. To maintain active membership in any component society, a doctor of medicine must maintain active membership in this Society and comply with all the provisions of the Bylaws of this Society and the component society. Physicians in training may become active members if they hold permanent licenses.

Sec. 4. ACTIVE MEMBERS—DUES EXEMPT—A member in any of the following three categories shall be classified as "Active—Dues Exempt" and shall have all the privileges of active membership:

(a) Hardship—A member for whom the payment of dues would be a financial hardship by reason of physician disability or illness may be excused, fully or partially, from payment of dues by The Council provided the member is fully or partially exempted from the payment of component society dues. A member may also be excused from payment of dues because of financial hardship, or for other reason, but these must be set forth by the secretary of the member's component society.

(b) Postgraduate study—Active membership may be maintained without payment of dues for any member who is out of practice on account of postgraduate medical studies or in an approved residency training program providing such dues exemption is given by the component medical society.

(c) Voluntary service—A member who serves as a missionary or who participates, for nominal or no compensation in a government-sponsored volunteer medical program, either in the United States or abroad.

Sec. 5. PHYSICIANS-IN-TRAINING—Component societies may admit to membership physicians still in training who have permanent licenses to practice medicine in Michigan. Such members shall have all privileges of active membership including the right to vote, but without the privilege of holding office. State Society dues shall be reduced to 50 percent of the regular dues for active members, and component society dues shall be reduced to an amount not to exceed 50 percent of the regular dues for active members.

Sec. 6. TEMPORARY LICENSEES AND STUDENTS—Component societies may admit to membership medical students, and physicians in training who do not have a permanent license, as Student Members. Student members shall not pay dues to this Society nor the component society. They may receive MSMS publications authorized by The Council. They may not vote or hold office, nor be eligible for other member benefits. They may be appointed to MSMS committees as advisors.

Sec. 7. RETIRED MEMBERS—A member who has maintained active membership in any one or more component societies in Michigan for a period of five or more years, and who has retired from practice, may be transferred to the retired members roster of such component society, provided his membership dues have been paid to the end of the preceding calendar year. A retired member shall pay no dues or assessments, but shall have the right to vote and hold office, and shall be entitled to receive publications at such rates as The Council may determine.

Upon request of the component society made at least thirty days in advance of an Annual Session of the House of Delegates and upon certification by the Secretary of this Society as to number of years of practice and membership in good standing, the House of Delegates may elect such member to retired membership in the Society.

Sec. 8. LIFE MEMBERS—

(a) A doctor of medicine who has maintained an active membership in good standing for twenty-five years in any one or more constituent state societies of the American Medical Association, with any five years in Michigan, with dues paid for the previous calendar year and who 1) has attained the age of 70 years or 2) has been in practice for 50 years, may, upon application and recommendation of his component society made at least 30 days in advance of an Annual Session of the House of Delegates, be elected by the House of Delegates to life membership in this society. Such election shall be preceded by certification of the State Society in which he has maintained membership as to the required number of years of membership and good standing.

(b) Upon the adoption of this subdivision (b) all then living Past Presidents, Past Chairmen of The Council and Past Speakers of the House of Delegates of this Society shall automatically become life members of this society and thereafter each President, Chairman of The Council and Speaker of the House of Delegates of this Society shall, upon retiring from office, become a life member of this Society without further action.

(c) A life member shall pay no dues or assessments but shall have the right to vote and hold office and shall be entitled to receive publications at such rates as The Council may determine.

Sec. 9. SERVICE MEMBERS—

(a) Military—A member in good standing who serves on active duty in the military forces of the United States may be transferred by the component society to Service Member status for the period of time he is in such service.

(b) Commissioned medical officers—A commissioned medical officer of the United States Army, Navy, Public Health Service or physician employed by the Veterans Administration, on duty in this State, who is not engaged in the private practice of medicine, may be granted Service Member status by the component society in the area where he is located.
Service members shall pay no dues and are not entitled to vote or hold office. They shall be entitled to receive publications at such rates as The Council may determine.

Sec. 10. HONORARY MEMBERS—A component society may elect as an honorary member any person distinguished for his services or attainments in medicine or the allied sciences, or who has rendered other services of unusual value to organized medicine or the medical profession. Upon recommendation of a component society, the House of Delegates may elect such person an honorary member of the society. An honorary member shall pay no dues and shall be without the right to vote or hold office in either this or the component society.

Sec. 11. NON-RESIDENT MEMBERS—A component society may elect as a non-resident member any doctor of medicine residing and practicing outside of the county who is a member in good standing of his own component society. A non-resident member shall not have the right to vote or hold office.

Sec. 12. AFFILIATE MEMBERS—Component societies may elect to affiliate membership lay persons in areas of endeavor which are related to medicine and medical practice. Affiliate members shall pay no dues and may not vote or hold office. They shall be entitled to receive publications at such rates as The Council may determine.

Sec. 13. RESOLUTIONS CONCERNING MEMBERSHIP CHANGES—Any change in membership status which requires action by the House of Delegates shall be effected by resolution presented in triplicate at an Annual Session of the House of Delegates after such secretarial certification as are required by these Bylaws.

COMMENT: The Committee believes that the membership classifications as now contained in the Bylaws are confusing, sometimes overlap, and should be modified to meet present needs.

The major changes recommended are:

(1) *Establishment of A New Category "Active Members—Dues Exempt"* This will include present provisions re exemption for hardship and for postgraduate study, now contained in Chapter 5. It also includes a dues-exempt category for physicians who serve as missionaries or in government-sponsored volunteer programs.

(2) *Deletion of the Associate Member Category* Persons now included in this category will be eligible for membership under other sections in the new Chapter.

(3) *Addition of Membership Category for "Students"* This category would allow medical students or physicians-in-training who do not hold permanent licenses to become student members. They would not be able to vote or hold office, nor be eligible for other member benefits. They would be permitted to serve on MSMS committees as advisors and would receive MSMS publications as authorized by The Council.

(4) *Establishment of A New Category "Service Members"* This would include previous categories of military members and commissioned medical officers.

(5) *Addition of Membership Category for "Affiliate Members"* This includes some members presently included under Associate Members and allows component societies to admit to membership lay persons in areas of endeavor related to medicine and medical practice. Such members would not vote or hold office.

(6) *Addition of Membership Category for "Physicians-in-Training"* This particular category, which was of the most concern to the House of Delegates when it considered this Chapter last spring, received a great deal of additional study by the Committee during the year.

You will recall that our recommendation last year was to allow physicians-in-training who are permanently licensed to become voting members of MSMS, but without the right to hold office. Dues would be reduced with the amount set by the House of Delegates and component society dues would be similarly reduced.

The Committee recognized that the component societies where large numbers of residents were located were much concerned as to the impact of such membership on their local society. The committee also recognized that the American Medical Association has urged all its constituent societies to move toward more involvement of house physicians in the affairs of organized medicine. This seemed to be a legitimate and ultimately rewarding goal for MSMS.

The committee considered several alternative proposals for membership for this group. Among these were:

(a) Permitting direct membership in MSMS for the period of training and establishment of an MSMS section for physicians-in-training. This could be at either full or reduced dues.

The committee did not favor this approach because it denies the physician-in-training involvement in organized medicine at the local level and in effect separates him from the local medical community. The establishment of a section did not appear feasible because of the lack of cohesiveness among residents in the widely separated areas of the state where they are located.

(b) Allowing physicians-in-training to pay full dues to the component society and reduced dues to MSMS, giving them the right to vote and hold office as well as all other membership privileges. The Committee felt that the total financial burden here would keep most physicians-in-training from joining their local societies and MSMS.

(c) Including physicians-in-training (whether temporarily or permanently licensed) and students in one category, with all benefits of membership except for voting and holding office, with payment of 10 percent dues to cover costs of maintaining the member benefit programs.

The committee agreed that, if member benefits were to be offered any members, they should pay sufficient dues to cover MSMS costs. However, it did not believe that these benefits should be offered to medical students.

In addition, the committee agreed that without the right to vote in some manner, there was no real involvement in organized medicine on the part of the physician-in-training.

(d) Admitting physicians-in-training only as full dues-paying Active Members. This approach was unsatisfactory since it would effectively preclude the membership of most house physicians because of the financial burden, and would remove the present provision for associate membership with no dues, and no vote. Thus, it would decrease rather than increase participation.

(e) Maintaining present Bylaws provisions—i.e., permitting physicians-in-training to be associate members, with eligibility for membership benefits except for the right to vote and hold office, with no dues.

The committee saw two objections to this: 1) physicians-in-training would not pay sufficient dues to cover the costs of member benefits to them, and 2) it does not allow for real participation, i.e., voting.

(f) Establishing a new Associate Member category for physicians-in-training and allowing them to choose either this or active membership. These Associate members would have all benefits of membership except the right to vote or hold office, including the right to become voting members of MSMS committees on appointment, with 10 percent dues.

This proposal again does not permit meaningful participation by involvement in the voting process.

The committee also considered several combinations of the above proposals, but all failed in some way to answer the various objections noted above.

The committee also considered alternative ways of giving some limited voting privileges, such as permitting these members to have a vote in the same proportion as they paid dues, i.e., one-half dues would entitle a physician to one-half a vote. However, this seemed so unwieldy that the committee did not believe it feasible.

In considering these various alternatives, it became apparent to the committee that the crux of the matter is this: In order to become meaningfully involved in organized medicine, physicians-in-training must be involved in all phases of activity, including the voting process. This, of necessity, implies that they will have some influence on the course of society activities.

MSMS (and the component societies) must decide, via the House of Delegates, whether or not it wishes to involve physicians-in-training in its activities.

The committee therefore recommends to the House that physicians-in-training be granted active membership at reduced dues, 50 percent at the state level, and no greater than 50 percent at the component society level, with all membership privileges including the right to vote, but without the right to hold office. It is noted that such active members would be included in the number which determines how many delegates from each componet society shall be seated in the MSMS House of Delegates.

The committee further stresses that, if the committee's recommendation is not accepted by the House, the House should select another alternative, either from among those noted above, or some other, so that Chapter 2 as revised can become operative without any further unnecessary delay.

Other minor changes in Chapter 2 include clarification of language re the necessity of being a member of MSMS to be a member of the component society and vice versa, minor changes in the provisions for retired membership, and other "housekeeping" changes.

THE REFERENCE COMMITTEE recommended adoption of the proposed revision of Chapter 2, Membership Classifications, with the following amended Section 5.

"Sec. 5. PHYSICIANS-IN-TRAINING

"a) Active—Component societies may admit to membership physicians still in training who have permanent licenses to practice medicine in Michigan. Such members shall have all privileges of active membership. State Society dues shall be reduced to 50 percent of the regular dues for active members, and component society dues shall be set locally.

"b) Associate—Physicians-in-training who have permanent licenses to practice medicine in Michigan may become associate members of the component society and of the State Society, with all membership privileges except the right to vote or hold office. State Society dues shall be set by The Council to cover administrative costs of membership, and component society dues shall be set locally."

THE HOUSE approved on first reading the proposed revision of Chapter 2, as amended. (In accordance with Bylaws provisions, it will be laid over to the next session for final reading.)

Remarks by Gov. William G. Milliken were reported in full in the November issue of *Michigan Medicine*, Vol. 72, Number 33.

Report of the Reference Committee on Ways and Means

David Siegel, MD, *Chairman*

Your Committee, at the request of Reference Committee "G," reviewed the financial implications of Resolutions 73A-31, 73A-32, and 73A-33, which have a projected cost of approximately $1,200. The Committee felt that the expenditures were worthwhile and that they could be incorporated in the 1974 budget.

Since this was the only business to come before your Committee, the Committee then concerned itself with the definition and clarification of its responsibilities.

The Committee sees as its primary responsibility the duty of furnishing cost estimates to the House on all motions requiring the expenditure of funds prior to final action by the House of Delegates.

The Committee also believes it has a responsibility to serve as a financial watchdog of the House of Delegates, seeking to review for the House action taken by its officers or by The Council which may have a financial impact on our membership.

The Committee also feels it must review the general fiscal policies and assure itself of the appropriateness.

At this time the Committee was gently pressured to consider the possibility of a dues increase. Despite the increases in today's cost of doing business and despite the preliminary projections for a deficit in the 1974 budget, your Committee believed that a possible deficit would be small enough so that it could be accommodated from reserves.

It becomes increasingly obvious, however, that the pressure for a dues increase will not disappear, and your Committee has made it very plain to our financial officers that this will only be considered in the face of an over-riding justification for same.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTIONS

● RESOLUTION 73A-1

Confidentiality of Death Certificate
Clark B. Smith, MD, Hillsdale County

House Action: Disapproved

Whereas, Certificates of Death are classified as public information and are freely accessible to anyone desiring a copy of one, and

Whereas, privileged medical information is contained on the death certificate, and

Whereas, making public this information violates the physician-patient privilege, therefore be it

RESOLVED: That MSMS draft and have introduced legislation which would protect the confidentiality of the medical information contained in the certificate.

● RESOLUTION 73A-2

Repeal of PSRO Amendment
Clark B. Smith, MD, Hillsdale County

House Action: Substitute Resolution (in lieu of 73A-2, 73A-17, 73A-18, and 73A-19) Adopted as Amended

Whereas, the PSRO Section of P.L. 92-603, October 30, 1972, is an existing statute, and

Whereas, this statute infringes upon:

1. Physician-patient relationship
2. Confidentiality
3. Freedom of choice of physician
4. Professional judgments by substituting computerized standards, and

Whereas, the statute intends quality medical services, it does, in fact, mainly address itself to cost-control, and

Whereas, the Secretary of H.E.W. is empowered to designate PSROs without relation to organized medicine, therefore, be it

RESOLVED: That the Michigan State Medical Society work for the repeal of the PSRO Section of P.L. 92-603 through all methods available, and be it further

RESOLVED: That the Michigan State Medical Society through The Council and the Ad Hoc Committee to Coordinate PSRO Activity in Michigan, continue to monitor developments in this area, and if the Bennett Amendment is not repealed, actively seek to amend its provisions to protect both the public and the medical profession and be it further

RESOLVED: That the Michigan State Medical Society develop viable alternative plans for the review of the delivery of quality medical services at reasonable costs and be it further

RESOLVED: That any implementation of PSRO be a decision of the House of Delegates of the Michigan State Medical Society, and be it further

RESOLVED: That this resolution be distributed to:

1. The House of Delegates of the American Medical Association by the Michigan Delegation to the American Medical Association.
2. To each State Medical Society.
3. To every member of the Michigan State Medical Society and to Michigan's two Senators and members of the House of Representatives.

● RESOLUTION 73A-3

Community Non-Sectarian Hospital Abortion Service Privileges
W. B. Long, MD, Calhoun County

House Action: Adopted as Amended

Whereas, abortion privileges have been determined to be a legal privilege by the U.S. Supreme Court, and the Michigan Department of Public Health with the aid and support of the Michigan State Medical Society has promulgated guidelines to assure proper control and quality medical procedure, and

Whereas, MSMS in its continuing support of abortion reform in past years has advocated the right of individuals to choose not to participate in abortions, and the right of sectarian institutions to choose not to provide such services, and

Whereas, some non-sectarian community non-profit hospital boards of trustees have taken advantage of the "conscience clause" to deny abortion services despite the willingness and desire of medical staffs to provide complete obstetrical and gynecological services. This raises serious barriers to the privileges of the medical staff and citizens alike to realized quality-oriented controlled medical abortion services as well as challenging the basic authority of medical staff prerogatives within the hospital, and

Whereas, there is no case law in Michigan and perhaps the nation as to the precise division of authorities between hospital boards and medical staff, and a determination of that division of authority has become a critical issue in the provision of abortion services, therefore be it

RESOLVED: That it is MSMS policy that physicians who have privileges in community non-sectarian hospitals shall have the authority to offer abortion services in that hospital, constrained only by the guidelines of the Department of Public Health, and be it further

RESOLVED: That MSMS use its influence to achieve this goal in all of Michigan community non-sectarian hospitals.

● RESOLUTION 73A-4

Repeal of State Sales Tax on Food and Prescription Drugs
Robert C. Kettunen, MD, Kalamazoo County

House Action: Adopted as Amended

Whereas, prescription drugs and medically prescribed devices are necessary for the health of the people of the State of Michigan, and

Whereas, the sales tax on prescription drugs poses a hardship to a segment of the population least able to pay, and

Whereas, the State of Michigan has many other sources of income such as the State Income Tax, The State Lottery, and sources other than taxes on prescription drugs, and

Whereas, an appropriate physician concern for patients dictates an interest in the cost of drugs and medically prescribed devices, therefore be it

RESOLVED: That the Michigan State Medical Society urges the Legislature to abolish the State sales tax on prescription drugs and medically prescribed devices.

● RESOLUTION 73A-5

Inequalities of Fee Profiles
Orville W. Oughtred, MD, Macomb County

House Action: Disapproved

Whereas, reimbursement of physicians by Michigan Blue

Shield still continues with concealment of many inequalities and discriminatory policies, therefore be it

RESOLVED: That MSMS ask Michigan Blue Shield to furnish medical practitioners the complete range of profiles, customary and prevailing charges on request, for any given procedure in the same socio-economic area.

● RESOLUTION 73A-6

Elevated Profiles of Recently Qualified Specialists
Orville W. Oughtred, MD, Macomb County

House Action: Disapproved

Whereas, with no relationship to previous earnings, Michigan Blue Shield grants higher profiles to recently qualified specialists in the same socio-economic area, therefore be it

RESOLVED: That MSMS request Michigan Blue Shield to raise profiles of established specialists to the same level, alleviating these obvious inequities.

● RESOLUTION 73A-7

Abandonment of Physicians' Profiles
Orville W. Oughtred, MD, Macomb County

House Action: Substitute Resolution (in lieu of 73A-7 and 73A-12) Adopted

Whereas, the MSMS position pertaining to fees, profiles and regionalization has been confusing, and

Whereas, there is frank inconsistency between resolution 72A-26 and resolution 73S-7, therefore, be it

RESOLVED: That MSMS again reaffirm its support of the concept of usual, customary, and reasonable fees without regionalization, and be it further

RESOLVED: That MSMS inform its members of methods whereby acceptable fees may be obtained and disagreements with third parties may be resolved equitably.

● RESOLUTION 73A-8

Regulation of Motor cycle Use
H. M. Andre, MD, Kent County

House Action: Adopted as Amended

Whereas, the number of motorcycles in use, and the density of motorcycle traffic is steadily increasing, and

Whereas, there is a consistent rapid rise in the incidence of motorcycle accidents, and

Whereas, despite present traffic and safety rules regarding motorcycle operation, there continues to be an increasing number of fatalities and very serious injuries resulting from motorcycle accidents, therefore be it

RESOLVED: The MSMS urge an education program on motorcycle safety through all available sources including, driver education courses, the Secretary of State, and the Department of Motor Vehicles.

● RESOLUTION 73A-9

Lifetime Medical Financing System
Richard E. Straith, MD, Oakland County

House Action: Referred, without action, to the Committee on Professional Insurance Plans for further study. (The House approved recommendations from the reference committee that (1) a comparison of the two contracts (Lifetime Medical Financing System and Blue Cross/Blue Shield Econo-Plan) be made by the Committee on Professional Insurance Plans and the Bureau of Economic Information, and (2) that the Bureau of Economic Information survey the members of the society about their interest in high deductible co-insurance programs for MSMS members.)

Whereas, the Lifetime Medical Financing System underwritten by the Independent Liberty Life Insurance Company of Grand Rapids is being offered for group purchase to the Michigan State Medical Society and could result in a premium reduction from $75 to $21 per month, and

Whereas, this concept was unanimously approved by the insurance committees of the Michigan State Medical Society, the Oakland County Medical Society and the Wayne County Medical Society, and

Whereas, the new econo-plan offered by Blue Cross and Blue Shield has serious defects about which the membership is not fully aware, and would do nothing to stem the tide of government encroachment into medical care, and

Whereas, the Michigan State Medical Society has already followed the Blue Cross philosophy for thirty years, and witnessed an uncontrollable rise of medical costs during this time, which has been accompanied by more and more government interference in the practice of medicine, and

Whereas, a change in national administration in 1976, without a solution to our medical financing problems, will surely be accompanied by a government medical system which will be unfavorable to the practice of medicine as we know and enjoy it, and

Whereas, the Michigan State Medical Society once before led the nation in the formation of the first medical financing system, and because the Lifetime Medical Financing System is a basic plan that can be expanded to solve our national medical financing problems, therefore be it

RESOLVED: That the Michigan State Medical Society House of Delegates request The Council to recommend and immediately implement the Lifetime Medical Financing System underwritten by the Independent Liberty Life Insurance Company for the members of the Michigan State Medical Society.

● RESOLUTION 73A-10

MSMS as a Spokesman for its Members
Marion G. McCall, Jr., MD, Wayne County

House Action: No Action

Whereas, in the full year since the House of Delegates last Annual Session, there has been some evidence that the physicians of Michigan have become more aware of the bureaucratic control of medical practice, and

Whereas, there is an urgent need to develop definite position for input in legislative debate as it concerns an inevitable national health insurance program, and

Whereas, there is an even more urgent necessity to develop the MSMS as a stalwart and authoritative spokesman on these issues, therefore be it

RESOLVED: That the House reconsider its actions on Resolutions 72A-5 and 72A-21.

RESOLUTION 72A-5

Subject: Prospective Payment to Subscribers

Whereas, the physicians of Michigan, by their establishment in 1939 of the Blue Shield Service Benefit Concept, and their majority support and participation in the program since have demonstrated the soundness of the service benefit concepts, and

Whereas, the citizens of Michigan in an acceptance of this program that has made it the major health insurer of the State, have demonstrated their desire for a service-benefit program, and

Whereas, prospective payment for medical services has been advocated and in some instances insisted upon by third parties, therefore be it

RESOLVED: That The Council of Michigan State Medical Society be empowered at its option, to call upon, and advise its physician membership to require a prospective deposit of the insured of any plan, at least equal to 90 percent of the estimated customary fee for elective, non-emergent medical services, and be it further

RESOLVED: That The Council shall advise its membership that any draft issued by third parties for such prospective payments be drawn payable only to the subscriber, and be it further

RESOLVED: That the physicians shall provide the subscriber with no more than the information required on the proposed "simplified claim form" for presentation to his insurer for prospective payment.

RESOLUTION 72A-21

Subject: The Participation of Physicians in Third Party Health Insurance Schemes

Whereas, in the matter of third party health insured plans, an informed carrier, and an informed provider can only result in a better and more effective public service, and

Whereas, the presently used system of defining participation of providers in these schemes have been a glaring source of nearly all the confusion and conflict in these programs, and

Whereas, an alternative, defined participation agreement can very likely resolve all but the philosophical objections to participation, therefore be it

RESOLVED: That the physicians of Michigan do require an alternative participation agreement from Medicaid and any third party that presume to provide service benefits, and be it further

RESOLVED: That physicians of Michigan do require that any agreement bear the prior endorsement of The Council of the Michigan State Medical Society, and be it further

RESOLVED: That the physicians of Michigan do require that said agreement will include at a minimum provision for:

a) A simplified claim procedure

b) A provision for timely payment and penalty for less than timely payment

c) A provision for timely notification to physicians of the third party's perception of the physicians' individual customary fee and a mechanism of resolving any disputes.

d) A definite time limit on the agreement with a statewide expiration date

e) A defined method of resolution of any individual case and general disputes between physician and intermediary

f) A recognition that the Physician Manual constitutes an integral part of this agreement and is not subject to unilateral alteration or interpretation

g) For proportional provision of basic liability coverage for a participating physician

h) An effective date of Nov. 1, 1972.

• RESOLUTION 73A-11

Discontinuance of Blue Shield Hospitality Room for Delegates
Arthur F. Dundon, MD, Grand Traverse-Leelanau-Benzie County

House Action: No Action

Whereas, there is intense pressure in these times to afford all possible economics in providing health care, including medical insurance, and

Whereas, Blue Shield has traditionally sponsored a hospitality room during the meetings of the House of Delegates of MSMS, and

Whereas, a small economy could result if Blue Shield ceased this practice for this organization; and perhaps a larger economy could result from cessation of this activity if it is afforded to other organizations, and

Whereas, the continuation of a Blue Shield hospitality room for the delegates at such meetings smacks of a cozy collusion between a major health insurance carrier and the policy making body of the medical profession thereby compromising the favorable image of both organizations, and

Whereas, MSMS could well heed the wisdom of the great American philosopher, Will Rogers, who once said, "There is no such thing as a free lunch," therefore be it

RESOLVED: That this 1973 House of Delegates of the Michigan State Medical Society request Blue Shield to now cease its practice of sponsoring a hospitality room for the delegates during the House of Delegates meetings with thanks for its generosity in the past.

• RESOLUTION 73A-12

Equal Fees for Equal Service
Edwin S. Woodworth, MD, Livingston County

House Action: Substitute Resolution (in lieu of 73A-7 and 73A-12) Adopted. See 73A-7.

• RESOLUTION 73A-13

Shortage of Physicians
Edwin S. Woodworth, MD, Livingston County

House Action: Substitutes Resolution (in lieu of 73A-13 and 73A-14) Adopted as Amended.

Whereas, the increase in need for more primary care physicians has been voiced in many quarters including the AMA Council on Health Manpower and the AMA Council on Medical Education, and

Whereas, the MSMS House of Delegates has gone on record before as recommending that our State Medical Schools increase the number of graduates per year, and

Whereas, to meet the need for more primary care physicians, there should be greater numbers and proportions of medical graduates engaged in residency training in the primary care specialties, especially family practice, and

Whereas, the AMA House of Delegates in June of 1973 advised immediate adoption of a goal to have at least 50 percent of all medical graduates enter residency training in primary care specialties in the coming years (Report Z of Board of Trustees of AMA), therefore be it

RESOLVED: That MSMS strongly urge the deans of the medical schools, and the directors of training programs of each of the six accredited family practice residencies in our state to take all appropriate action to encourage and enhance the development of primary care residency programs, and be it further

RESOLVED: That this House of Delegates of MSMS strongly urge and work to support and encourage increasing numbers of medical graduates to enter residency training in the primary care specialties as soon as feasible in coming years, and be it further,

RESOLVED: That a copy of this resolution be sent to the Boards of Trustees of all hospitals affiliated with the Michigan Hospital Association.

• RESOLUTION 73A-14

Need for Primary Care Physicians
Robert J. Toteff, MD, Saginaw County

House Action: Substitutes Resolution (in lieu of 73A-13 and 73A-14) Adopted as Amended. See 73A-13.

• RESOLUTION 73A-15

Involuntary Sterilization
Thomas Flake, MD, Wayne County

House Action: Substitute Resolution (in lieu of 73A-15) Adopted.

Whereas, it has been learned that young women receiving welfare or welfare-like support from governmental agencies have been involuntarily sterilized, and

Whereas, there is additional evidence that such women in the childbearing age have been forced, by physicians, to consent to sterilization under duress, and

Whereas, such practices are in direct violation of the rights of the poor among us, and are further a blatant prima facie abuse and violation of the privileges and ethics of medical licensure, therefore be it

RESOLVED: The MSMS condemns the practice of Involuntary Sterilization without due legal process, and be it further

RESOLVED: That the MSMS delegation to the AMA request the AMA Judicial Commission to investigate and take whatever action is necessary in instances of alleged involuntary sterilization without due legal process, and be it further

RESOLVED: That The Council of MSMS request the Maternal Health Committee of MSMS to study the problem of involuntary sterilization and make whatever recommendation it deems necessary regarding this issue to The Council.

• RESOLUTION 73A-16

Encourage Generic Prescribing
Aaron K. Warren, MD, Cass County

House Action: Adopted as Amended

Whereas, Michigan physicians are interested in the best care for their patients at the least cost to their patients, and

Whereas, the cost of prescription drugs can be a burden on many of our individual citizens, therefore be it

RESOLVED: That MSMS support existing anti-substitution drug laws, and be it further

RESOLVED: That the individual practitioner be encouraged to prescribe generically when, in his opinion, it will not affect the medical treatment and may lower the cost to the patient.

• RESOLUTION 73A-17

Opposition to PSRO
W. J. Liedel, MD, Monroe County

House Action: Substitute Resolution (in lieu of 73A-2, 73A-17, 73A-18, and 73A-19) Adopted as Amended. See 73A-2.

• RESOLUTION 73A-18

Opposition to PSRO
W. J. Liedel, MD, Monroe County

House Action: Substitute Resolution (in lieu of 73A-2, 73A-17, 73A-18, and 73A-19) Adopted as Amended. See 73A-2.

• RESOLUTION 73A-19

Opposition to PSRO
W. J. Liedel, MD, Monroe County

House Action: Substitute Resolution (in lieu of 73A-2, 73A-17, 73A-18, and 73A-19) Adopted as Amended. See 73A-2.

• RESOLUTION 73A-20

Discriminatory and Unfair Controls on Health Care Providers
Robert E. Paxton, MD, Newaygo County

House Action: Adopted as Amended

Whereas, the House of Delegates of MSMS passed the amended resolution 73S-16, "That the MSMS continue to seek relief from the constrictive and restrictive policies in regard to physician's fees in phase III of the Board of Economic Stabilization," and that such restrictions continue to be in force, and

Whereas, the current practice of limiting fees of all health and related fields, especially with continuing inflation, is unfair, therefore, be it

RESOLVED: That the MSMS instruct our AMA Delegation to encourage the AMA to take necessary legal action to effectually eliminate the discriminatory and unfair restrictions currently imposed on health care providers, and further to support present intervening legal actions.

• RESOLUTION 73A-21

Rotating Internship
William Haeck, MD, Kent County

House Action: Adopted as Amended

Whereas, at the time it gave its approval to the abolition of the internship, almost all medical schools in the United States required four years prior to the awarding of the MD degree, and

Whereas, many medical schools have shortened their curriculum to three years in the interim, and

Whereas, the MSMS is concerned that medical students and/or house staff physicians are inexperienced in terms of comprehensive patient care, therefore be it

RESOLVED: That MSMS urge the AMA, the various specialty boards, and the deans of the medical schools to insure themselves that doctors in training have adequate exposure to a broad concept of patient care.

• RESOLUTION 73A-22

Legislative Funds—Post Graduate Medical Education
William Haeck, MD, Kent County

House Action: No Action. The House approved a recommendation from the reference committee that The MSMS Council take the following action:

1. To request the "Task Force on Graduate Medical Education in Michigan to permit The MSMS Council to appoint additional members to represent geographic areas and interest groups not now represented by the MSMS representatives appointed to the task force.

2. To instruct The MSMS Council to designate the six physicians appointed to the Task Force to form an ad hoc MSMS committee to study the issues for the State Medical Society.

3. To instruct this new MSMS ad hoc committee to undertake an in-depth study of the Indiana Program and other existing programs dealing with the same subject as they relate to (1) financing, (2) graduate training evaluation, and (3) the impact of the total program on existing medical practice and manpower.

4. To request the new MSMS committee to also investigate and explore the present and future sources of funding for graduate medical education in Michigan.

5. And that The MSMS Council request the ad hoc committee to study these matters, and that The Council present a report to the 1974 Spring meeting of the MSMS House of Delegates.

Whereas, the Spring meeting of the MSMS House of Delegates approved an ad hoc committee report recommending "that The MSMS Council should continue its study of a possible proposal to the Michigan legislature requesting state appropriations for post-graduate training programs for interns and residents, and

Whereas, a special section of the August issue of *Michigan Medicine* contains two articles citing both state and national problems in Graduate Education implying causes and remedies that are at best, controversial, and

Whereas, The MSMS Council has appointed a group of physicians (not representative of the state geographically nor of the existing leadership in graduate education in the state) to study and further develop the proposal, and

Whereas, a proposal has been presented to several interested groups in the state and said proposal would create under contract with the state Department of Public Health, a non-profit corporation whose proposed Board of Directors include 8 medical educators, 4 representatives of insurance companies (Blue Cross, Blue Shield, health insurance council, Department State Social Services), 3 house staff (2 MD, 1 DO), and one representative each of the Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons and the Michigan Hospital Association and Michigan Osteopathic Hospital Association, and

Whereas, this proposal would empower this corporation to approve and disapprove institutions, programs and methods of spending allocated funds, would further empower this corporation to determine which institutions could offer particular programs, to further determine the number of and types of graduate programs within these institutions and to evaluate both the programs, the teachers and trainees, and

Whereas, the "first-year sample budget" for this program in this proposal is for 3 million dollars taken from taxpayers' contributions to create a central authority to govern and regulate education in Michigan in all institutions receiving legislative subsidy, therefore be it

RESOLVED: 1) The Michigan State Medical Society reaffirm its interest in and responsibility for advising the legislature concerning effective programs of patient care, medical education, including the development of optimum quality medical education programs designed to attract large numbers of the finest graduates of our nation's medical schools

2) That the Michigan State Medical Society go on record as favoring a pluralistic rather than a monolithic approach to this problem

3) That the Michigan State Medical Society appoint a truly representative committee of recognized medical educators and practicing physicians to review, with open hearings, various proposals involving the use of legislative funds to support and improve graduate education programs in medicine in Michigan

4) That the committee appointed include a representative nominated by the staff of each of the institutions in Michigan offering graduate education programs plus an equal number of practicing MDs

5) That pending the hearings and findings and report of such a committee, the Michigan State Medical Society and its Council refrain from endorsing any specific proposal involving legislative funding or support of Graduate Medical Education.

● RESOLUTION 73A-23

Compliment Governor Milliken re Environment
Alvin Bonzelaar, MD, Ottawa County

House Action: Substitute Resolution (in lieu of 73A-23) Adopted

RESOLVED: That MSMS commend Governor Milliken for his vigorous pursuit of reorganization in the state government as it relates to the protection of the health of man and his environment.

● RESOLUTION 73A-24

Financing Medical Education
Benjamin Jeffries, MD, Wayne County
for the Wayne County Delegation

House Action: Referred, without action, to appropriate Educational Committee for study and recommendation at next House of Delegates meeting

Whereas, medical education is lengthy and costly, and

Whereas, medical education is vital to the welfare of the citizens of this State, therefore be it

RESOLVED: That the Michigan State Medical Society urge the state legislature to obtain appropriate low cost loans and grants for medical students in the various state universities.

● RESOLUTION 73A-25

Support of Hospital Medical Staff
Benjamin Jeffries, MD, Wayne County
for the Wayne County Delegation

House Action: Adopted

Whereas, Hospital Boards of Trustees are responsible for the overall conduct of hospital management, and

Whereas, physicians are responsible for the care of patients, and

Whereas, physicians' duties are diverse and often individualistic, and

Whereas, the manner in which the physician practices is affected by hospital rules and regulations, therefore be it

RESOLVED: That Michigan State Medical Society support a policy that hospital medical staff bylaw changes be made only in consultation with and approval of the medical staff.

● RESOLUTION 73A-26

Combatting Hypertension
Benjamin Jeffries, MD, Wayne County
for the Wayne County Delegation

House Action: Adopted

Whereas, hypertension leads to serious disability and health, and

Whereas, means are at hand to significantly control hypertension in its early stages, and

Whereas, the general public must be informed of the dangers of hypertension for early diagnosis and treatment, therefore be it

RESOLVED: That the Michigan State Medical Society approve the concept of a national program to combat hypertension.

● RESOLUTION 73A-27

Supporting Immunization Month
Benjamin Jeffries, MD, Wayne County
for the Wayne County Delegation

House Action: Adopted as Amended

Whereas, immunization is vital to protect the general health of our communities, therefore be it

RESOLVED: That the Michigan State Medical Society support "Immunization Month" this October, 1973 and that it be an on-going program throughout the coming year, and be it further

RESOLVED: That MSMS encourage component societies to support and publicize local immunization programs.

● RESOLUTION 73A-28

MD Placement in Health Council
Benjamin Jeffries, MD, Wayne County
for the Wayne County Delegation

House Action: Adopted as Amended

Whereas, the Michigan Health Council has performed well throughout its long existence by placing physicians in areas medically understaffed, and

Whereas, this function properly belongs to such a Council, therefore be it

RESOLVED: That the Michigan State Medical Society work to improve the Liaison with and continue to support the Michigan Health Council and be it further

RESOLVED: That the Michigan State Medical Society promote disseminaiton of more public and professional information re the function and purposes of the Michigan Health Council.

● RESOLUTION 73A-29

Student Membership
Benjamin Jeffries, MD, Wayne County
for the Wayne County Delegation

House Action: No Action

Whereas, it is desirable to know the problems of medical students, and

Whereas, it is desirable to inform medical students about the activities of component medical societies, therefore be it

RESOLVED: That Michigan State Medical Society and its component societies seek ways to encourage a membership for medical students.

● RESOLUTION 73A-30

Intern-Resident Division
Benjamin Jeffries, MD, Wayne County
for the Wayne County Delegation

House Action: No Action

Whereas, it is desirable to involve physicians in postgraduate training in the affairs of medical societies, to increase understanding and to share mutual problems, therefore be it

RESOLVED: That Michigan State Medical Society establish a section of medical house staff officers.

● RESOLUTION 73A-31

A Single Plan for Medical Care Insurance
Benjamin Jeffries, MD, Wayne County
for the Wayne County Delegation

House Action: Adopted as Amended

Whereas, it appears that the enactment of a National Health Program will not occur at the present, and

Whereas, the medical profession has the responsibility of not only health care but also its delivery in the least costly and most efficient manner, and

Whereas, the present situation provides the medical profession a final opportunity to demonstrate its willingness and capability to present a modification of the present fine system of medical care which will enable cost and program predictability, therefore be it

RESOLVED: That the House of Delegates appoint an Ad Hoc Committee to study in depth and develop medically accepted guidelines for a positive program for comprehensive health insurance which might include the following suggestions:

1. Community rating of medical care insurance with a single program of benefits for all subscribers, by all carriers.
2. Service benefits wherein the subscriber will receive his care as provided in the single program.
3. A schedule for all benefits which will be known to all.
4. Stability of premium cost by a degree of financial participation on the part of the patient at the time of use of the benefit program.
5. Financial participation at the time of use in the form of co-insurance and/or deductible to be collected by the insurance carrier, the physician to be paid totally as expressed in the schedule.
6. That Michigan State Medical Society enlist the participation of all of its members, and represent them in implementing this program,

and be it further

RESOLVED: That the Ad Hoc Committee commence its study immediately using hearings involving all interested or concerned persons or groups whether by invitation or appearance, and be it further

RESOLVED: That the Ad Hoc Committee, assisted by the personnel and resources of the Michigan State Medical Society submit a preliminary report to be sent to each delegate and alternate on Dec. 1, 1973, for written comment. A final report shall be presented at the Spring meeting of the House of Delegates.

● RESOLUTION 73A-32

Governmental Role in Financing Medical Indigents
Benjamin Jeffries, MD, Wayne County
for the Wayne County Delegation

House Action: Adopted

Whereas, in the event that an Ad Hoc Committee has been appointed to study a modification of Health Care Insurance, and

Whereas, there are many of the citizens of Michigan who do not belong to employed groups or are unable to afford premium cost and financial participation at time of use, and

Whereas, present governmental means of financing health care of these citizens is costly, inefficient, redundant, therefore be it

RESOLVED: That the Ad Hoc Committee consider the care of our less affluent citizens by embodying the following:

1. Premiums for the community-rated single program be borne by the appropriate governmental agency, paid to the appropriate insurance carrier.
2. The financial participation at time of use will be collected from the appropriate governmental agency.
3. Fee-for-service benefits will be those of the known schedule and will be paid to the physician whether he be in solo practice or member of any group, and be it further

RESOLVED: That the Ad Hoc Committee shall report on this matter at the time and in the manner prescribed in its previous resolution.

● RESOLUTION 73A-33

Medical Care Delivery to the Needy
Benjamin Jeffries, MD, Wayne County
for the Wayne County Delegation

House Action: Adopted

Whereas, there are considerable numbers of citizens who are medically indigent or otherwise medically under-privileged, and

Whereas, much lip service has been paid to the problem but only a handful of physicians have attempted diligently to do something, and

Whereas, this is a problem which must be of paramount concern to Michigan State Medical Society and its component societies, in the interest of the community and involvement of all physicians, and all physicians must participate in its solution, and

Whereas, these citizens must be brought into the mainstream of the existing medical care system and not be the focus of development of a new artificial contrivance, therefore be it

RESOLVED: That the House of Delegates appoint a Committee on Medical Care Delivery to the needy to study the following:

1. Development of a system which will utilize all physicians in any given area, and provide physicians for needy areas.
2. Development of an educational program directed toward physicians to stress the importance and urgency of accepting civic responsibility,

and be it further

RESOLVED: That this committee begin its study immediately, consulting interested and concerned persons or groups, assisted by the personnel and resources of the Michigan State Medical Society and the Michigan Health Council. A preliminary report shall be prepared by Jan. 1, 1974, and circulated appropriately. A final report shall be presented to the House of Delegates at its Spring meeting.

● RESOLUTION 73A-34

Open Hearing for Members
Sidney E. Chapin, MD, Wayne County

House Action: Substitute Resolution (in lieu of 73A-34) Adopted

Whereas, members of the Michigan State Medical Society appear reluctant to participate in local and statewide medical society activities, and

Whereas, input from diverse members is desirable, and

Whereas, although local and state mechanisms already exist to hear the voice of the physician, therefore be it

RESOLVED: That the Michigan State Medical Society urges its component societies to promote and publicize the existing communication channels for the purpose of increasing information exchange between the membership, delegates, and the headquarters of the Michigan State Medical Society, and be it further

RESOLVED: That component Medical Societies hold open meetings for the membership on pertinent topics, and be it further

RESOLVED: That copies of this resolution should be distributed to the President, President-Elect, Secretary, Delegates and Chairman of Delegates of each component Medical Society.

• RESOLUTION 73A-35

Constitutional Amendment on Abortion
Lee B. Stevenson, MD, for the Committee on Maternal and Perinatal Health

House Action: Adopted

Whereas, the United States Supreme Court has ruled that abortions are a private matter between physician and patient, and that ruling is consistent with MSMS and AMA policy on medical control of abortion, and

Whereas, the guidelines of the court ruling do not restrict the physician's ability to make proper medical judgment but do place restrictions on stage of pregnancy and location of termination to protect the health of women and the third trimester fetus, and

Whereas, there are no coercive elements in the decision which would require women or physicians or other health personnel to participate in abortion procedures, and

Whereas, Federal laws have been passed to protect those who object to participation in abortions, to prevent experimentation on the live fetus, and to protect sectarian institutions from suit for non-participation, and

Whereas, there is a national compaign to amend the Constitution of the United States to prohibit abortions from the moment of conception for any reason except to save the life of the woman, and

Whereas, passage of the constitutional amendment would prohibit abortion even for the most pressing medical indications, therefore be it

RESOLVED: That the House of Delegates of MSMS go on record as opposed to the amendment of the Constitution of the United States which would prohibit abortion, and be it further

RESOLVED: That MSMS request that the MSMS delegation to the AMA House of Delegates introduce the above resolution to the next AMA House and to instruct the staff of the AMA to work to oppose the attempts to amend the Constitution of the United States to prohibit abortions.

SPECIAL MEMBERSHIPS

The Reference Committee on Special Memberships, Donald N. Fitch, MD, Chairman, recommended approval of the following special memberships as recommended by the component medical societies and certified by the secretary of MSMS in accordance with the Bylaws:

RETIRED MEMBERSHIPS—members who have maintained membership for 10 years in the component medical society and retired from active practice.

Allegan County—G. B. Goddard, MD.

Alpena County—T. W. Wienczewski, MD.

Berrien County—M. E. Friedman, MD; August F. Bliesmen, MD.

Branch County—Robert J. Fraser, MD.

Calhoun County—Alice F. Campbell, MD; Robert K. Curry, MD.

Delta-Schoolcraft County—James H. Fyvie, MD.

Eaton County—B. Phillip Brown, MD.

Isabella-Clare County—D. A. Soriano, MD.

Kalamazoo County—Milland J. Roberts, MD.

Kent County—Charles M. Bell, MD; Virgil E. Stover, MD.

Livingston County—Florence J. C. Perry, MD.

Macomb County—Joseph N. Scher, MD.

Midland County—Leonard A. Poznak, MD.

Oakland County—William J. McElroy, MD; William H. Koehler, MD; William K. Tregenza, MD.

Ottawa County—Harold G. DeVries, MD; W. B. Bloemendal, MD; John W. Ver Duin, MD.

Saginaw County—Frederick P. Brender, MD; Earl E. Kleinschmidt, MD.

St. Joseph County—Stanley C. Penzotti, MD.

Van Buren County—Bert Diephuis, MD.

Washtenaw County—Myron E. Wegman, MD; Scott T. Harris, MD; Rudolf E. Nobel, MD.

Wayne County—James H. Blain, Jr., MD; Viola G. Brekke, MD; Hugo O. Horny, MD; Melbourne J. King, MD; Hugh H. Miley, MD George C. Thosteson, MD.

Wexford-Missaukee County—John C. Inman, MD.

ASSOCIATE MEMBERSHIP

Wayne County—S. A. Goosen, hospital administrator

LIFE MEMBERSHIP—member who has maintained membership for 25 years in a constituent state society of the American Medical Association with five years in Michigan and has either obtained the age of 70 or been in practice 50 years.

Genesee County—Clifford W. Colwell, MD; James E. Hawkins, MD; Benjamin F. Sniderman, MD; Clayton K. Stroup, MD; Carver G. Wolcott, MD.

Gratiot County—Alfred L. Aldrich, MD; Myron G. Becker, MD; Joseph H. Bergin, MD; Richard L. Waggoner, MD; Rex A. Wilcox, MD.

Ingham County—J. K. Altland, MD; Carl W. Bradford, MD; John A. Cowan, MD; Frank B. Heckert, MD; Lester C. Kraft, MD.

Kalamazoo County—John D. Littig, MD; Gerald H. Rigterink, MD; Jack Foy Wu, MD.

Kent County—Paul W. Kniskern, MD; William B. Scott, MD.

Macomb County—Frederick A. Sturm, MD.

Oakland County—W. Meredith Green, MD; Felix J. Kemp, MD; James C. Moloney, MD.

Washtenaw County—Walter Belser, MD; F. Bruce Fralick, MD; William A. Murray, MD; Ernest H. Watson, MD; Frederick B. Williamson, MD.

Wayne County—Gaylord S. Bates, MD; Germany E. Bennett, MD; Moe Baumer, MD; I. Marvin Burstein, MD; Norman W. Flaherty, MD; Reece H. Horton, MD; Donold J. Jaffar, MD; Reuben R. Kallman, MD; Nathan J. Kapetansky, MD; Joseph A. Kurcz, MD; Hugh M. Mahoney, MD; Lyndle R. Martin, MD; E. Bert McCollum, MD; Aage E. Nielsen, MD; Aaron Z. Rogers, MD; Max Silverman, MD; John G. Slevin, MD; Sadie Thumin, MD; Henry Turkel, MD; Max J. Wainger, MD; Irvin I. Wiesenthal, MD.

THE HOUSE adopted the report of the Reference Committee.

PRESENTATION AND AWARDS

FIFTY YEAR AWARDS

President John J. Coury, MD, presented the Fifty Year Awards to:

Walter G. Bernard, MD, Wayne County
Leonard C. Blakey, MD, Monroe County
Myrton S. Chambers, MD, Genesee County
Donald Chandler, MD, Kent County
Charles H. Ewing, MD, Wayne County
Weldon A. Gift, MD, Sanilac County
W. Leonard Howard, MD, Muskegon County
Edward H. Lauppe, MD, Wayne County
William M. LeFevre, MD, Muskegon County
Samuel J. Levin, MD, Wayne County
Pedro O. Martinez, MD, Wayne County
Benjamin Montgomery, MD, Chippewa County
Alton E. Pullon, MD, Kalamazoo County
Samuel H. Ruskin, MD, Wayne County
James W. Townsend, MD, Jackson County
Verne L. VanDuzen, MD, Washtenaw County
Frank VanSchoick, MD, Jackson County
Neil J. Whalen, MD, Wayne County
Edward A. Wishropp, MD, Wayne County

Fifty Year Awards subsequently were presented to the following doctors who were unable to attend:

Vinton A. Bacon, MD, Wayne County
Theodore I. Bauer, MD, Ingham County
Dean C. Burns, MD, Emmet County
Harold W. Carlson, MD, Wayne County
James E. Croushore, MD, Wayne County
Laurence A. Chrouch, MD, Wayne County
Harry O. Davidson, MD, Wayne County
Leon DeVel, MD, Kent County
William N. Edmonds, MD, Wayne County
Henry C. Galantowicz, MD, Wayne County
Darrel B. Galerneau, MD, Wayne County
Charles Gitlin, MD, Wayne County
George L. Gundry, MD, Genesee County
Howard H. Heffron, MD, Lenawee County
A. Ray Hufford, MD, Kent County
Joseph A. Johnston, MD, Wayne County
Albert Kerlikowske, MD, Washtenaw County
Melvin O. Kernick, MD, Wayne County
Stewart C. McArthur, MD, Isabella County
Henry K. Ransom, MD, Washtenaw County
Ernest R. Reinsh, MD, Wayne County
William L. Shields, MD, Wayne County
Richard F. Sterba, MD, Wayne County
Howard S. Willson, MD, Ingham County
Thomas G. Wilson, MD, Bay County

EMPLOYEE AWARDS

Secretary Kenneth H. Johnson, MD, presented the following employee awards as previously authorized by the House of Delegates:

Robert J. Roney—25 years of service
Helen A. Schulte—30 years of service

NATIONAL PRESIDENTS AWARDS

Awards were presented to the following for their service as presidents of national medical organizations:

G. Jan Beekhuis, MD, Detroit, American Academy of Facial Plastic and Reconstructive Surgery, Inc.

Stuart M. Gould, Jr., MD, Ann Arbor, National Association of Private Psychiatric Hospitals

Robert M. Heavenrich, MD, Saginaw, American Academy of Pediatrics

James W. Rae, Jr., MD, Ann Arbor, American Congress of Rehabilitation Medicine.

FLAG AWARDS

Awards were presented to the following doctors who have served as presidents of state-wide non-medical organizations:

Raymond E. Fuller, MD, Grand Rapids, Michigan Heart Association

Charles O. Long, Jr., MD, Lansing, Michigan Division American Cancer Society

Walter A. Meier, MD, Monroe, Michigan TB and Respiratory Disease Association

Robert E. Rice, MD, Greenville, Michigan Health Council

Harry C. Saltzstein, MD, Michigan Chapter, American Medical Writers Association

ELECTIONS

The House of Delegates elected the following MSMS Officers, Councilors, and American Medical Association Delegates and Alternate Delegates:

Officers *(to Spring 1975)*

President-Elect .... Brock E. Brush, MD, Detroit
Secretary .... Kenneth H. Johnson, MD, Lansing
Treasurer .... John R. Ylvisaker, MD, Pontiac
Assistant Secretary .... David Siegel, MD, Lansing
Assistant Treasurer .... Ernest P. Griffin, Jr., MD, Flint
Speaker of the House .. Vernon V. Bass, MD, Saginaw
Vice Speaker of the House
.... James D. Fryfogle, MD, Southfield

Councilors *(to Spring 1977)*

1st District .... Louis E. Heideman, MD, Birmingham
1st District .... Ralph R. Cooper, MD, Detroit
1st District .... Benjamin Jeffries, MD, Harper Woods
1st District .... Marion McCall, MD, Detroit*
4th District ...... W. Kaye Locklin, MD, Kalamazoo
5th District .. Noyes L. Avery, Jr., MD, Grand Rapids
6th District .... Ernest P. Griffin, Jr., MD, Flint
14th District .... Donato F. Sarapo, MD, Adrian
**(to fill unexpired term to 1977 Spring Annual Session)*

Delegates to the American Medical Association
(Jan. 1, 1974 through Dec. 31, 1975)

Otto K. Engelke, MD, Ann Arbor
Paul T. Lahti, MD, Royal Oak
John W. Moses, MD, Detroit
Robert E. Rice, MD, Greenville

Alternate Delegates to the American Medical Association *(Jan 1, 1974 through Dec. 31, 1975, in order of seniority)*

Frank B. Walker, II, MD, Grosse Pointe Park
Richard J. McMurray, MD, Flint
Brooker L. Masters, MD, Fremont
Donald T. Anderson, MD, Kingsford

REFERENCE COMMITTEES—FALL SESSION 1973

COMMITTEE A

D. Bonta Hiscoe, MD, Ingham, Chairman
John C. Benson, MD, Genesee
Norman Bolton, MD, Wayne
Henry T. Forsyth, MD, Shiawassee
Marion G. McCall, MD, Wayne
Bernard J. Sweeney, MD, Internal Med.
Edwin S. Woodworth, MD, Livingston

Councilor Advisors:

Robert M. Stow, MD, Ingham
Louis E. Heideman, MD, Wayne
W. Kaye Locklin, MD, Kalamazoo

COMMITTEE B

John W. Moses, MD, Wayne, Chairman
Alvin Bonzelaar, MD, Ottawa
Ned I. Chalat, MD, Wayne
Lyle D. Elliott, MD, Washtenaw
Robert H. Evans, MD, St. Joseph
Earl G. Moehn, MD, Macomb
J. H. McLaughlin, MD, Oakland

Councilor Advisors:

Ralph R. Cooper, MD, Wayne
Raymond L. Hockstad, MD, Delta
Adam C. McClay, MD, Grand Traverse

COMMITTEE C

Richard H. Gascoigne, MD, Lenawee, Chairman
David S. Greenbaum, MD, Gastroenterology Sec.
Gerald H. Mandell, MD, Wayne
Marjorie Peebles Meyers, MD, Wayne
Thomas C. Payne, MD, Ingham
Kenneth J. Ray, MD, Wayne
Gordon W. Willoughby, MD, Internal Med.

Councilor Advisors:

James H. Tisdel, MD, St. Clair
Louis R. Zako, MD, Wayne

COMMITTEE D

Lewis Simoni, MD, Genesee, Chairman
Fred Brace, MD, Kent
Harry C. George, MD, Ingham
Cecelia Hissong, MD, Wayne
Kenneth H. Musson, MD, Grand Traverse
James A. Read, MD, Oakland
Homer Smathers, MD, Wayne

Councilor Advisors:

Brooker L. Masters, MD, Newaygo
Sydney Scher, MD, Macomb

COMMITTEE E

Benjamin Jeffries, MD, Wayne, Chairman
Robert D. Allaben, MD, Wayne
Joseph A. Caruso, MD, Ob/Gyn Section
Worth Henderson, MD, Oakland
Stephen C. Mason, MD, Psychiatry Sec.
Robert E. Paxton, MD, Newaygo
Aaron K. Warren, MD, Cass

Councilor Advisors:

Leland E. Holly, II, MD, Muskegon
Donato F. Sarapo, MD, Lenawee

COMMITTEE F

John W. Grigg, MD, Bay, Chairman
Thomas R. Berglund, MD, Kalamazoo
Dwight J. Dutcher, MD, Wayne
Robert Jardinico, MD, Saginaw
John W. MacKenzie, MD, Genesee
Charles C. Vincent, MD, Wayne
George M. Wilson, MD, Marquette

Councilor Advisors:

William A. DeYoung, MD, Saginaw
Robert C. Prophater, MD, Bay

COMMITTEE G

Harold J. Falls, MD, Washtenaw, Chairman
Eli J. Igna, MD, Wayne
William S. Jones, MD, Menominee
Arnold L. Brown, MD, Oakland
George Mogill, MD, Wayne
Robert J. Toteff, MD, Saginaw
S. A. Yannitelli, MD, Calhoun

Councilor Advisors:

James D. Fryfogle, MD, Oakland
Paul T. Lahti, MD, Oakland

CONSTITUTION & BYLAWS

Lee B. Stevenson, MD, Wayne, Chairman
Donald I. Bryan, MD, Wayne
Paul R. Dumke, MD, Wayne
Arthur F. Dundon, MD, Grand Traverse
David J. Millard, MD, Van Buren
Neil Vanselow, MD, Washtenaw
Leo W. Walker, MD, Pathology Section

Councilor Advisors:

Donald T. Anderson, MD, Dickinson
Noyes L. Avery, Jr., MD, Kent

WAYS & MEANS

David Siegel, MD, Urology Sec., Chairman
Richard C. Deming, MD, Jackson
Thomas M. Flake, MD, Wayne
James M. Grost, MD, Clinton
Richard J. McMurray, MD, Genesee
Thomas J. Setter, MD, Macomb
Robert W. Black, MD, Wayne

Councilor Advisor:

Ernest P. Griffin, Jr., MD, Genesee

CREDENTIALS & TELLERS

George F. Poretta, MD, Wayne, Chairman
Vickers C. Hansen, MD, Manistee
James J. Humes, MD, Wayne
William Middleton, U-M, SAMA
Fred L. Wedeking, MD, Kalamazoo
Daniel J. Wilhelm, MD, St. Clair
Charles H. Willison, MD, Midland

RULES & ORDER OF BUSINESS

Edward E. Elder, MD, Oakland, Chairman
Harvey M. Andre, MD, Kent
James C. Danforth, MD, Wayne
Robert J. Fisher, MD, Washtenaw
Louis F. Hayes, MD, Wayne
Robert J. Rice, MD, Ionia-Montcalm
Paul L. Trump, MD, Dickinson

SPECIAL MEMBERSHIPS

Donald N. Fitch, MD, Delta, Chairman
William Haeck, MD, Kent
James M. Kennary, MD, Wayne
Richard E. Straith, MD, Plastic Surgery Section
Arthur A. Ulmer, MD, Wayne
Dennis E. VanAlst, MD, Wexford
John J. Vrbanac, MD, Oceana

1973 FALL MSMS HOUSE OF DELEGATES RECORD OF ATTENDANCE

	Meeting				
OFFICERS	1st	2nd	3rd	4th	5th
Speaker:					
Vernon V. Bass, MD	x	x	x	x	x
Vice-Speaker:					
James D. Fryfogle, MD	x	x	x	x	x
Immed. Past President:					
Sidney Adler, MD	—	—	x	—	—
Secretary:					
Kenneth H. Johnson, MD	x	x	x	x	x
COUNTY MEDICAL SOCIETY DELEGATES					
ALLEGAN					
Richard L. Plagenhoef, MD	x	x	x	x	x
ALPENA-ALCONA-PRESQUE ISLE					
F. C. O'Dell, Jr., MD	x	x	x	x	x
BARRY					
Not Represented					
BAY-ARENAC-IOSCO					
John W. Grigg, MD	x	x	x	x	x
BERRIEN					
Fredk. H. Lindenfeld, MD	x	x	x	x	x
F. Alan Kennedy, MD	x	x	x	x	x
BRANCH					
Henry C. Gomley, MD					
Malcolm D. Steider, MD	x	x	x	x	x
CALHOUN					
George T. Kelleher, MD	x	—	—	—	—
Ralph A. Cram, MD	—	x	—	—	—
William D. Walters, MD	—	—	x	x	—
S. A. Yannitelli, MD	x	x	x	x	x
Walter B. Long, MD	x	x	x	x	x
CASS					
Aaron K. Warren, MD	—	x	x	x	—
CHIPPEWA-MACKINAC					
B. T. Montgomery, MD	x	x	—	—	—
CLINTON					
James M. Grost, MD	x	x	x	x	—
DELTA-SCHOOLCRAFT					
Donald N. Fitch, MD	x	x	x	x	—
DICKINSON-IRON					
Not Represented					
EATON					
Daniel Joseph, MD	x	x	x	x	—
GENESEE					
John W. MacKenzie, Jr., MD	x	x	x	x	x
Charles A. Thompson, MD	x	x	x	x	x
John C. Benson, MD	x	x	x	x	x
Lewis E. Simoni, MD	x	x	x	x	—
Richard J. McMurray, MD	—	x	x	x	x
John Quin, Jr., MD	—	x	x	x	x
Joseph T. Batdorf, MD					
Carl H. Mangelsdorf, MD	x	x	—	—	—
Phyllis O. Helcher, MD	—	—	—	x	—
GOGEBIC					
Not Represented					

	Meeting				
	1st	2nd	3rd	4th	5th
GRAND TRAVERSE-LEELANAU-BENZIE					
Arthur F. Dundon, MD	x	x	x	x	—
Kenneth H. Musson, MD	x	—	x	x	—
GRATIOT					
Jack M. Stack, MD	x	x	x	x	x
HILLSDALE					
Clark B. Smith, MD	x	x	x	x	—
HOUGHTON-BARAGA-KEWEENAW					
Paul G. Goodreau, MD	x	x	x	x	x
HURON					
Charles W. Oakes, Jr., MD	x	x	x	x	x
INGHAM					
Donald J. Aiken, MD	x	x	x	x	x
Thomas C. Blair, MD	x	x	x	x	x
George D. Stilwill, MD	x	x	x	x	x
D. Bonta Hiscoe, MD	x	x	x	x	x
Henry E. Malcolm, MD	x	x	x	x	—
Harry C. George, MD	x	x	x	x	—
Thomas C. Payne, MD	x	—	x	x	—
IONIA-MONTCALM					
Robert E. Rice, MD	x	x	x	x	—
ISABELLA-CLARE					
John M. Wood, MD	x	x	x	x	x
JACKSON					
Edward R. Weddon, MD	x	x	x	—	—
Richard C. Deming, MD	x	x	x	—	—
KALAMAZOO					
Thomas R. Berglund, MD	x	x	x	x	—
Robert C. Kettunen, MD	—	x	x	—	—
Paul L. VanDenBrink, MD	x	x	x	x	—
Phillip B. Stott, MD	x	x	—	—	—
Fred L. Wedeking, MD	x	—	—	—	—
KENT					
Harvey M. Andre, MD	x	x	x	x	x
Victor A. Notier, MD	x	x	x	x	—
William E. Kincaid, MD	x	x	x	x	—
Jack G. Lukens, MD	x	x	x	x	—
Fred C. Brace, MD	x	x	x	x	—
William Haeck, MD	x	x	x	x	—
Richard A. Rasmussen, MD	x	x	x	x	x
Robert D. Burton, MD	x	x	x	x	—
Gordon L. Bartek, MD	x	x	x	x	—
LAPEER					
Charles E. Conaway, MD	x	x	x	x	—
LENAWEE					
Richard H. Gascoigne, MD	x	—	—	x	—
LIVINGSTON					
Edwin S. Woodworth, MD	x	x	x	x	—
LUCE					
Not Represented					
MACOMB					
Earl G. Moehn, MD	x	x	x	x	x
Thomas J. Setter, MD	x	x	x	x	x
Joseph J. LaHood, MD	x	x	x	x	x
Ronald J. Sables, MD	x	x	x	x	x
Jule J. Merritt, MD Orville W. Oughtred, MD	x	x	x	x	x
MANISTEE					
Vickers C. Hansen, MD	x	x	x	x	x
MARQUETTE-ALGER					
George M. Wilson, Jr., MD	x	x	x	x	—
MASON					
William F. Sutter, MD	x	x	x	x	—
MECOSTA-OSCEOLA-LAKE					
Jerome A. Conrad, MD	x	x	x	x	—

	Meeting				
	1st	2nd	3rd	4th	5th
MENOMINEE					
John R. Heidenreich, MD	—	x	x	x	x
MIDLAND					
Charles H. Willison, MD	x	x	x	x	—
MONROE					
Warren J. Liedel, MD	x	x	x	—	—
MUSKEGON					
Leland E. Holly, II, MD	x	x	x	x	x
Richard T. Allen, MD	x	x	x	x	x
Donald K. Crandall, MD	x	x	x	x	—
NEWAYGO					
Robert E. Paxton, MD	x	x	x	x	x
NORTH CENTRAL					
Lloyd T. Wiegerink, MD	x	x	x	x	x
NORTHERN MICHIGAN					
Russell F. LaBeau, MD	x	x	x	—	—
OAKLAND					
Kenneth L. Urwiller, MD	x	x	x	x	—
John B. Bryan, MD	x	x	x	x	x
Keith M. Holmes, MD	x	x	—	x	x
Edwin J. Westfall, MD	x	x	x	x	—
Worth W. Henderson, MD	x	x	x	x	x
John H. McLaughlin, MD	x	x	x	x	x
Peter A. Duhamel, MD	x	x	x	—	—
Edward E. Elder, Jr., MD	x	x	x	x	x
Arnold L. Brown, MD	x	x	x	x	—
James A. Read, MD	x	—	x	x	x
Francis A. Martin, MD	x	x	—	—	—
Fred W. Bryant, MD	x	x	x	x	—
Jaime V. Aragones, MD	x	x	—	—	—
Nanette J. Jagnow, MD	x	x	x	x	x
Richard E. Straith, MD	x	x	x	—	—
OCEANA					
John J. Vrbanac, MD	x	x	x	x	x
ONTONAGON					
James P. Strong, MD	x	x	x	x	—
OTTAWA					
Alvin Bonzelaar, MD	x	x	x	x	x
SAGINAW					
Robert J. Toteff, MD	x	x	x	x	x
Richard C. Hausler, MD	x	x	x	x	x
Robert Jardinico, MD	x	x	x	x	x
ST. CLAIR					
Daniel J. Wilhelm, MD	x	x	x	x	x
Charles N. Hoyt, MD James J. Snider, MD	x	x	x	—	—
ST. JOSEPH					
Robert H. Evans, MD	x	x	x	x	x
SANILAC					
Keate T. McGunegle, MD	x	x	—	x	x
SHIAWASSEE					
Henry T. Forsyth, MD	x	x	x	x	x
TUSCOLA					
Mitchell Urban, MD	x	x	x	x	—
VAN BUREN					
David J. Millard, MD	x	x	x	x	x
WASHTENAW					
Dean P. Carron, MD	x	x	x	x	x
Lyle D. Elliott, MD	x	x	x	—	—
Harold F. Falls, MD	x	x	x	x	x
George H. Koepke, MD	x	x	—	—	—
Robert J. Fisher, MD	x	x	x	x	—
Neal A. Vanselow, MD	x	x	x	x	—
Stuart M. Gould, Jr., MD	x	x	x	—	—
Leonard H. Wolin, MD	x	x	x	—	—
Joseph J. Tiziani, MD	x	x	x	x	—

	Meeting 1st	2nd	3rd	4th	5th
WAYNE					
Sidney Adler, MD	—	—	x	—	—
Robert D. Allaben, MD	x	x	x	x	x
Richard D. Anslow, MD	x	x	—	x	x
Raymond J. Barrett, MD	—	x	—	—	—
Robert W. Black, MD	—	—	x	x	x
Alexander Blain, III, MD	x	x	x	x	x
James B. Blodgett, MD	x	x	x	x	x
Norman Bolton, MD	—	—	x	x	—
Brock E. Brush, MD	x	x	—	—	x
Donald I. Bryan, MD	—	x	—	x	x
Ned I. Chalat, MD	x	x	x	x	x
Sidney E. Chapin, MD	x	x	x	x	x
Ralph R. Cooper, MD	x	x	x	x	x
James C. Danforth, Jr., MD	—	x	x	x	x
Henry M. Domzalski, MD	—	x	x	x	x
Dwight J. Dutcher, Jr., MD	x	x	x	x	x
Lee E. Feldkamp, MD	x	x	x	x	x
Thomas M. Flake, MD	x	—	x	x	—
John F. Fennesey, MD	—	x	x	—	—
Boy Frame, MD	x	x	x	—	—
C. Jackson France, MD	—	x	x	x	—
E. J. Freitas, MD	x	x	x	x	—
James D. Fryfogle, MD	x	—	—	—	x
Thomas Ganos, MD	x	x	x	—	—
Robert H. Hamburg, MD	x	x	x	x	—
Louis F. Hayes, MD	x	x	x	x	x
Louis E. Heideman, MD	x	—	x	x	—
Cecelia F. Hissong, MD	x	x	x	x	—
Andrew J. Hopkins, MD	x	—	—	—	x
Homer A. Howes, MD	x	x	x	x	x
James J. Humes, MD	x	x	—	x	x
Eli J. Igna, MD	x	x	x	x	—
Benjamin Jeffries, MD	x	x	x	x	x
James M. Kennary, Sr., MD	x	x	—	—	—
Conrad Lam, MD	x	x	x	x	—
Robert P. Lilly, MD	x	—	—	—	x
Gerald H. Mandell, MD	x	—	x	x	x
Robert E. McKnight, MD	x	—	—	—	—
Marjorie Peebles Meyers, MD	x	x	x	x	x
Marion G. McCall, MD	—	x	x	x	x
John W. Moses, MD	x	—	x	—	—
Roger F. McNeill, MD	x	x	x	x	x
George F. Porretta, MD	x	x	x	x	—
Kenneth J. Ray, MD	x	—	—	x	x
F. P. Rhoades, MD	x	x	x	x	x
Clarence E. Rupe, MD	x	x	—	—	—
Homer M. Smathers, MD	x	x	x	x	x
Lee B. Stevenson, MD	x	x	x	x	x
Donald N. Sweeny, Jr., MD	x	x	x	—	—
Arthur A. Ulmer, MD	x	x	x	—	x
Donald W. Visscher, MD	x	—	—	—	—
Milton R. Weed, MD	x	x	x	x	—
Louis R. Zako, MD	x	—	—	x	x
WEXFORD-MISSAUKEE					
Dennis E. Van Alst, MD	x	x	x	x	—
MEDICAL SCHOOLS					
MICHIGAN STATE UNIVERSITY					
Not Represented					
WAYNE STATE UNIVERSITY					
William Holden	—	—	—	x	—
UNIVERSITY OF MICHIGAN					
Not Represented					

SECTION DELEGATES

	Meeting 1st	2nd	3rd	4th	5th
ALLERGY & APPLIED IMMUNOLOGY					
Peter P. Barlow, MD	x	—	x	—	—
ANESTHESIOLOGY					
Barry G. Smiler, MD	x	—	x	—	—
DERMATOLOGY					
Not Represented					
GASTROENTEROLOGY					
David S. Greenbaum, MD	x	x	—	x	—
GENERAL PRACTICE					
George A. Dean, MD	x	x	—	—	—
INTERNAL MEDICINE					
Bernard J. Sweeney, MD	x	x	x	x	—
NEUROLOGY					
Mark C. Levine, MD	—	x	x	—	—
NEUROLOGICAL SURGEONS					
Not Represented					
OBSTETRICS-GYNECOLOGY					
Joseph A. Caruso, MD	x	x	x	x	—
OCCUPATIONAL MEDICINE					
Not Represented					
OPHTHALMOLOGY					
William D. Knapp, MD	x	—	—	—	—
ORTHOPEDIC SURGERY					
Hira E. Branch, MD	x	x	x	—	—
OTOLARYNGOLOGY					
John W. Grigg, MD	x	x	x	x	x
PATHOLOGY					
Leo W. Walker, MD	x	x	—	—	—
PEDIATRICS					
Not Represented					
PHYSICAL MEDICINE					
Jack R. Grommons, MD	—	x	x	—	—
PLASTIC SURGERY					
Not Represented					
PROCTOLOGY					
Not Represented					
PSYCHIATRY					
Stephen C. Mason, III, MD	x	x	x	x	—
PUBLIC HEALTH & PREVENTIVE MEDICINE					
Winston B. Prothro, MD	—	x	—	—	—
RADIOLOGY					
Kenneth D. McGinnis, MD	x	x	x	x	—
SURGERY					
Michael N. Zelenock, MD	x	x	x	x	x
THORACIC SURGERY					
Not Represented					
UROLOGY					
David Siegel, MD	x	x	x	x	x

Michigan Medicine

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VOLUME 72, NUMBER 3 • JANUARY 1973

Roster of MSMS Members

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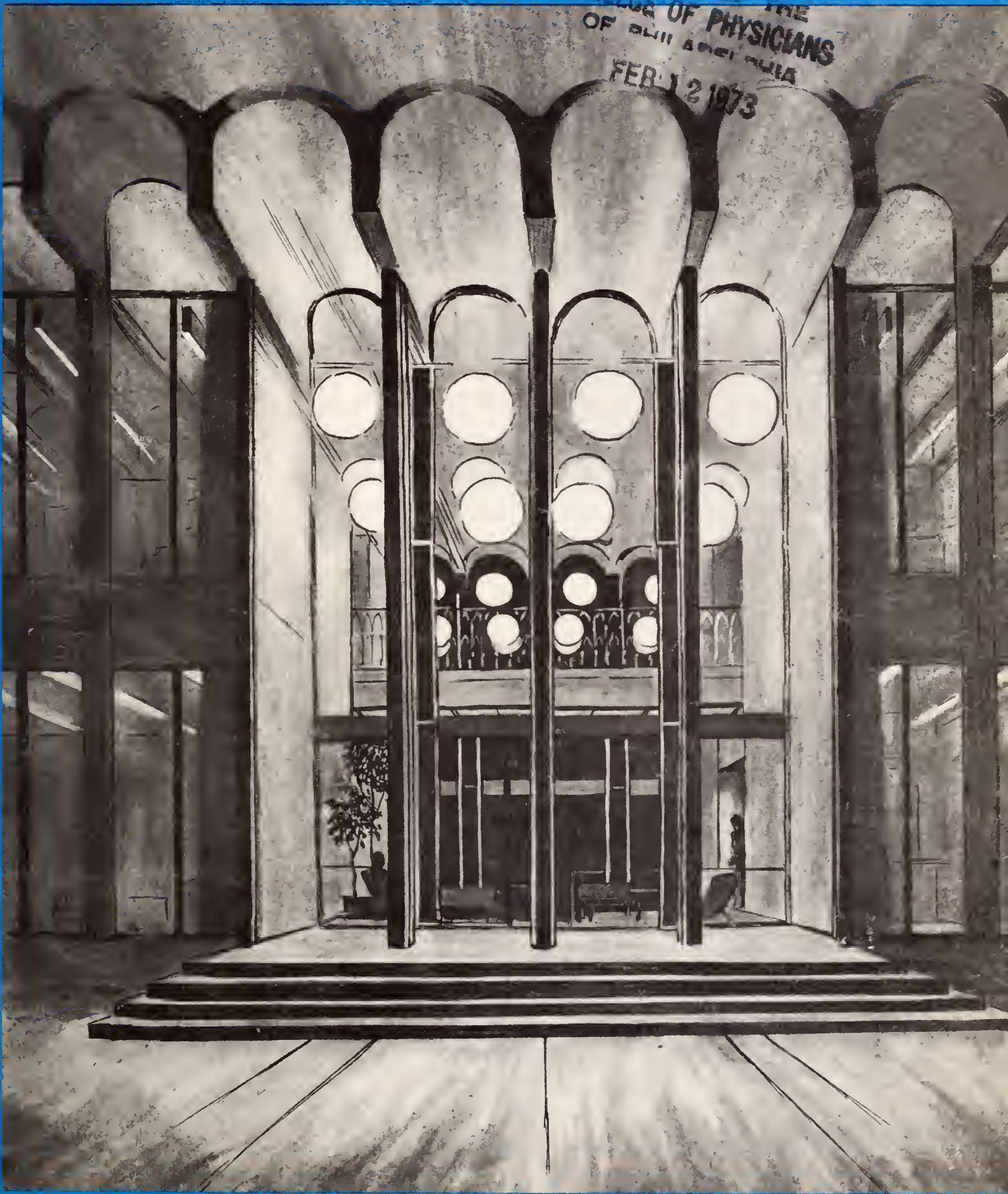

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MICHIGAN STATE MEDICAL SOCIETY DIRECTORY

This directory contains an alphabetical listing of each member with his county society code number. The list below shows the code number for each county. The listing also indicates the special membership categories: "L" for Life Member; "M" for Military Members; "N" for Non-Resident Members; "R" for Retired Members; "A" for Associate Members; "O" for Osteopathic; "H" for Honorary. All others are Active Members. The directory lists those members as of Dec. 1, 1972.

EXAMPLE:
John J. Smith, M.D. — 102 (Kalamazoo County)
333 Cedar Street — R (Retired Member)
Kalamazoo, Michigan — 49007 (Zip Code)

Alcona County (Alpena-Alcona-Presque Isle)	.014
Alger County (Marquette-Alger)	.134
Allegan County	.010
Alpena County (Alpena-Alcona-Presque Isle)	.014
Antrim County (Northern Michigan)	.170
Arenac County (Bay-Arenac-Iosco)	.022
Baraga County (Houghton-Baraga-Keweenaw)	.082
Barry County	.018
Bay County (Bay-Arenac-Iosco)	.022
Benzie County (Grand Traverse-Leelanau-Benzie)	.070
Berrien County	.026
Branch County	.030
Calhoun County	.034
Cass County	.038
Charlevoix County (Northern Michigan)	.170
Cheboygan County (Northern Michigan)	.170
Chippewa County (Chippewa-Mackinac)	.042
Clare County (Isabella-Clare)	.096
Clinton County	.046
Crawford County (North Central Counties)	.150
Delta County (Delta-Schoolcraft)	.050
Dickinson County (Dickinson-Iron)	.054
Eaton County	.058
Emmet County (Northern Michigan)	.170
Genesee County	.062
Gladwin County (North Central Counties)	.150
Gogebic County	.066
Grand Traverse County (Grand Traverse-Leelanau-Benzie)	.070
Gratiot County	.074
Hillsdale County	.078
Houghton County (Houghton-Baraga-Keweenaw)	.082
Huron County	.086
Ingham County	.090
Ionia County (Ionia-Montcalm)	.094
Iosco County (Bay-Arenac-Iosco)	.022
Iron County (Dickinson-Iron)	.054
Isabella County (Isabella-Clare)	.096
Jackson County	.098
Kalamazoo County	.102
Kalkaska County (North Central Counties)	.150
Kent County	.106
Keweenaw County (Houghton-Baraga-Keweenaw)	.082
Lake County (Mecosta-Osceola-Lake)	.142
Lapeer County	.110
Leelanau County (Grand Traverse-Leelanau-Benzie)	.070
Lenawee County	.114
Livingston County	.118
Luce County	.122
Mackinac County (Chippewa-Mackinac)	.042
Macomb County	.126
Manistee County	.130
Marquette County (Marquette-Alger)	.134
Mason County	.138
Mecosta County (Mecosta-Osceola-Lake)	.142
Menominee County	.146
Midland County	.154
Missaukee County (Wexford-Missaukee)	.226
Monroe County	.158
Montcalm County (Ionia-Montcalm)	.094
Montmorency County (North Central Counties)	.150
Muskegon County	.162
Newaygo County	.166
North Central (Crawford, Gladwin, Kalkaska, Montmorency, Ogemaw, Oscoda, Otsego, Roscommon)	.150
Oakland County	.174
Oceana County	.178
Ogemaw County (North Central Counties)	.150
Ontonagon County	.182
Osceola County (Mecosta-Osceola-Lake)	.142
Oscoda County (North Central Counties)	.150
Otsego County (North Central Counties)	.150
Ottawa County	.186
Presque Isle County (Alpena-Alcona-Presque Isle)	.014
Roscommon County (North Central Counties)	.150
Saginaw County	.190
St. Clair County	.194
St. Joseph County	.198
Sanilac County	.202
Schoolcraft County (Delta-Schoolcraft)	.050
Shiawassee County	.206
Tuscola County	.210
Van Buren County	.214
Washtenaw County	.218
Wayne County	.222
Wexford County (Wexford-Missaukee)	.226

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The artist's rendition of the MSMS Headquarters on the cover of the directory is by Alice Powers of Escanaba.

Guide to Help Locate Cities within the Counties

This guide matches up the counties for Michigan communities containing doctors.

Ada (Kent)
Addison (Lenawee)
Adrian (Lenawee)
Albion (Calhoun)
Algonac (St. Clair)
Allegan (Allegan)
Allendale (Ottawa)
Allen Park (Wayne)
Alma (Gratiot)
Almont (Lapeer)
Alpena (Alpena)
Ann Arbor (Washtenaw)
August (Kalamazoo)

Bad Axe (Huron)
Baldwin (Lake)
Bangor (Van Buren)
Baraga (Baraga)
Bark River (Delta)
Battle Creek (Calhoun)
Bay City (Bay)
Bay View (Emmet)
Bear Lake (Manistee)
Belding (Ionia)
Bellaire (Antrim)
Belleville (Wayne)
Benton Harbor (Berrien)
Berkley (Oakland)
Berrien Center (Berrien)
Berrien Springs (Berrien)
Bessemer (Gogebic)
Beulah (Benzie)
Big Rapids (Mecosta)
Birch Run (Saginaw)
Birmingham (Oakland)
Blanchard (Isabella)
Blissfield (Lenawee)
Bloomfield Hills (Oakland)
Bloomingdale (Van Buren)
Boyne City (Charlevoix)
Branch (Mason)
Breckenridge (Gratiot)
Bridgeport (Saginaw)
Bridgman (Berrien)
Brighton (Livingston)
Bronson (Branch)
Brooklyn (Jackson)
Brown City (Sanilac)
Buchanan (Berrien)
Byron Center (Kent)

Cadillac (Wexford)
Caledonia (Kent)
Calumet (Houghton)
Camden (Hillsdale)
Capac (St. Clair)
Carleton (Monroe)
Caro (Tuscola)
Caseville (Huron)
Cass City (Tuscola)
Cassopolis (Cass)
Cedar Springs (Kent)
Center Line (Macomb)
Centreville (St. Joseph)
Champion (Marquette)
Charlevoix (Charlevoix)
Charlotte (Eaton)
Chassell (Houghton)
Cheboygan (Cheboygan)
Chelsea (Washtenaw)
Chesaning (Saginaw)
Clare (Clare)
Clarkston (Oakland)
Clawson (Oakland)
Clinton (Lenawee)
Clio (Genesee)
Coldwater (Branch)
Coleman (Midland)
Coloma (Berrien)
Colon (St. Joseph)
Columbiaville (Lapeer)
Concord (Jackson)
Constantine (St. Joseph)
Coopersville (Ottawa)
Corunna (Shiawassee)
Croswell (Sanilac)
Crystal Falls (Iron)
Custer (Mason)

Daggett (Menominee)
Davison (Genesee)
Dearborn (Wayne)
Dearborn Heights (Wayne)
Decatur (Van Buren)
Deckerville (Sanilac)
Deerfield (Lenawee)
Delton (Barry)
Detroit (Wayne)
Dewitt (Clinton)
Dexter (Washtenaw)
Douglas (Allegan)
Dowagiac (Cass)
Drayton Plains (Oakland)
Drummond Island (Chippewa)
Dundee (Monroe)
Durand (Shiawassee)

Eagle Harbor (Keweenaw)
East Detroit (Macomb)
East Jordan (Charlevoix)
East Lansing (Ingham)
East Tawas (Iosco)
Eaton Rapids (Eaton)
Ecorse (Wayne)
Edmore (Montcalm)
Edwardsburg (Cass)
Elk Rapids (Antrim)
Elkton (Huron)
Eloise (Wayne)
Elsie (Clinton)
Engadine (Mackinac)
Escanaba (Delta)
Essexville (Bay)
Evart (Osceola)

Fairgrove (Tuscola)
Farmington (Oakland)
Farwell (Clare)
Fennville (Allegan)
Fenton (Genesee)
Fenwick (Montcalm)
Ferndale (Oakland)
Flat Rock (Wayne)
Flint (Genesee)
Flushing (Genesee)
Fowlerville (Livingston)
Frandor (Ingham)
Frankenmuth (Saginaw)
Frankfort (Benzie)
Franklin (Oakland)
Fraser (Macomb)
Freeland (Saginaw)
Fremont (Newaygo)

Galesburg (Kalamazoo)
Garden City (Wayne)
Gaylord (Otsego)
Gladstone (Delta)
Gladwin (Gladwin)
Glen Arbor (Leelanau)
Gobles (Van Buren)
Goodrich (Genesee)
Grand Beach (Berrien)
Grand Blanc (Genesee)
Grand Haven (Ottawa)
Grand Ledge (Eaton)
Grand Marais (Alger)
Grand Rapids (Kent)
Grandville (Kent)
Grant (Newaygo)
Grayling (Crawford)
Greenville (Montcalm)
Grosse Ile (Wayne)
Gwinn (Marquette)

Hamburg (Livingston)
Hamilton (Allegan)
Hamtramck (Wayne)
Hancock (Houghton)
Hanover (Jackson)
Harbert (Berrien)
Harbor Beach (Huron)
Harbor Springs (Emmet)
Harper Woods (Wayne)
Harrison (Clare)
Harrisville (Alcona)
Harsens Island (St. Clair)
Hart (Oceana)
Hartford (Van Buren)
Haslett (Ingham)
Hastings (Barry)
Hazel Park (Oakland)
Hemlock (Saginaw)
Hessel (Mackinac)
Hickory Corners (Barry)
Highland (Oakland)
Highland Park (Wayne)
Hillsdale (Hillsdale)
Holland (Ottawa)
Holly (Oakland)
Holt (Ingham)
Homer (Calhoun)
Horton (Jackson)
Houghton (Houghton)
Howell (Livingston)
Hudson (Lenawee)
Hudsonville (Ottawa)
Huntington Woods (Oakland)

Imlay City (Lapeer)
Indian River (Cheboygan)
Inkster (Wayne)
Ionia (Ionia)
Iron Mountain (Dickinson)
Iron River (Iron)
Ironwood (Gogebic)
Ishpeming (Marquette)
Ithaca (Gratiot)

Jackson (Jackson)
Jamestown (Ottawa)
Jonesville (Hillsdale)

Kalamazoo (Kalamazoo)
Kalkaska (Kalkaska)
Keego Harbor (Oakland)
Kent City (Kent)
Kinde (Huron)
Kingsford (Dickinson)

Lake City (Missaukee)
Lakeland (Livingston)

Lake Odessa (Ionia)
Lake Orion (Oakland)
Lakeview (Montcalm)
Lambertville (Monroe)
L'Anse (Baraga)
Lansing (Ingham)
Lapeer (Lapeer)
La Salle (Monroe)
Lathrup Village (Oakland)
Laurium (Houghton)
Lawrence (Van Buren)
Lawton (Van Buren)
Leonidas (St. Joseph)
Leslie (Ingham)
Lincoln Park (Wayne)
Linden (Genesee)
Litchfield (Hillsdale)
Livonia (Wayne)
Lowell (Kent)
Ludington (Mason)
Luther (Lake)
Luzerne (Oscoda)

Mackinaw Island (Mackinac)
Madison Heights (Oakland)
Manchester (Washtenaw)
Manistee (Manistee)
Manistique (Schoolcraft)
Manitou Beach (Lenawee)
Marcellus (Cass)
Marine City (St. Clair)
Marion (Osceola)
Marlette (Sanilac)
Marquette (Marquette)
Marshall (Calhoun)
Martin (Allegan)
Marysville (St. Clair)
Mason (Ingham)
Mecosta (Mecosta)
Melvindale (Wayne)
Memphis (St. Clair)
Menominee (Menominee)
Merrill (Saginaw)
Metamora (Lapeer)
Michigan Center (Jackson)
Middleville (Barry)
Midland (Midland)
Milan (Washtenaw)
Milford (Oakland)
Millington (Tuscola)
Mio (Oscoda)
Monroe (Monroe)
Montague (Muskegon)
Montrose (Genesee)
Morenci (Lenawee)
Mount Clemens (Macomb)
Mount Morris (Genesee)
Mount Pleasant (Isabella)
Muir (Ionia)
Mullet Lake (Cheboygan)
Munising (Alger)
Muskegon (Muskegon)
Muskegon Heights (Muskegon)

Nashville (Barry)
Negaunee (Marquette)
Newaygo (Newaygo)
Newberry (Luce)
New Buffalo (Berrien)
New Era (Oceana)
New Port (Monroe)
Niles (Berrien)
North Branch (Lapeer)
North Muskegon (Muskegon)
Northport (Leelanau)
Northville (Wayne)
Norway (Dickinson)

Oak Park (Oakland)
Okemos (Ingham)
Olivet (Eaton)
Onaway (Presque Isle)
Onsted (Lenawee)
Ontonagon (Ontonagon)
Orchard Lake (Oakland)
Oscoda (Iosco)
Ossineke (Alpena)
Otisville (Genesee)
Otsego (Allegan)
Ovid (Clinton)
Owosso (Shiawassee)
Oxford (Oakland)

Parchment (Kalamazoo)
Parma (Jackson)
Paw Paw (Van Buren)
Pentwater (Oceana)
Petoskey (Emmet)
Pigeon (Huron)
Pinckney (Livingston)
Pinconning (Bay)
Plainwell (Allegan)
Pleasant Lake (Jackson)
Pleasant Ridge (Oakland)
Plymouth (Wayne)
Pontiac (Oakland)
Portage (Kalamazoo)
Port Huron (St. Clair)
Portland (Ionia)
Potterville (Eaton)
Prudenville (Roscommon)
Pullman (Allegan)

Quincy (Branch)

Reading (Hillsdale)
Reed City (Osceola)
Reese (Tuscola)
Remus (Mecosta)
Richland (Kalamazoo)
Richmond (Macomb)
River Rouge (Wayne)
Riverview (Wayne)
Rives Junction (Jackson)
Rochester (Oakland)
Rockford (Kent)
Rockwood (Wayne)
Rogers City (Presque Isle)
Romeo (Macomb)
Romulus (Wayne)
Roscommon (Roscommon)
Rosebush (Isabella)
Roseville (Macomb)
Royal Oak (Oakland)

Saginaw (Saginaw)
Sagola (Dickinson)
Saline (Washtenaw)
Sandusky (Sanilac)
Sanford (Midland)
Saranac (Ionia)
Saugatuck (Allegan)
Sault Sainte Marie (Chippewa)
Sawyer (Berrien)
Schoolcraft (Kalamazoo)
Scottville (Mason)
Sebewaing (Huron)
Shelby (Oceana)
Sidney (Montcalm)
Southfield (Oakland)
Southgate (Wayne)
South Haven (Van Buren)
South Lyon (Oakland)
Sparta (Kent)
Spring Lake (Ottawa)
Stambaugh (Iron)
Standish (Arenac)
Stanton (Montcalm)
St. Charles (Saginaw)
St. Clair (St. Clair)
St. Clair Shores (Macomb)
Stephenson (Menominee)
Sterling Heights (Macomb)
St. Ignace (Mackinac)
St. James (Charlevoix)
St. Johns (Clinton)
St. Joseph (Berrien)
St. Louis (Gratiot)
Stockbridge (Ingham)
Sturgis (St. Joseph)
Sunfield (Eaton)
Suttons Bay (Leelanau)
Swartz Creek (Genesee)

Tawas City (Iosco)
Taylor (Wayne)
Tecumseh (Lenawee)
Temperance (Monroe)
Three Rivers (St. Joseph)
Traverse City (Grand Traverse)
Trenton (Wayne)
Troy (Oakland)
Trufant (Montcalm)

Ubly (Huron)
Union City (Branch)
Union Lake (Oakland)
Utica (Macomb)

Vandalia (Cass)
Vassar (Tuscola)
Vicksburg (Kalamazoo)
Vulcan (Dickinson)

Wakefield (Gogebic)
Walkerville (Oceana)
Walled Lake (Oakland)
Warren (Macomb)
Waterford (Oakland)
Watervliet (Berrien)
Wayland (Allegan)
Wayne (Wayne)
Weidman (Isabella)
Wellston (Manistee)
West Branch (Ogemaw)
Westland (Wayne)
Westphalia (Clinton)
White Cloud (Newaygo)
Whitehall (Muskegon)
White Pigeon (St. Joseph)
White Pine (Ontonagon)
Whitmore Lake (Washtenaw)
Williamston (Ingham)
Wixom (Oakland)
Wyandotte (Wayne)
Wyoming (Kent)

Yale (St. Clair)
Ypsilanti (Washtenaw)

Zeeland (Ottawa)

ALPHABETICAL LISTING OF MSMS MEMBERS

This directory contains an alphabetical listing of each member with his county society code number on the same line as his name. The list of counties with the code numbers is on page 1.

EXAMPLE:
John J. Smith, M.D. 102 (Kalamazoo County)
333 Cedar Street R (Retired Member)
Kalamazoo, Michigan 49007 (Zip Code)

A

HUGO A AACH MD 102
425 SORRENTO CT R
PUNTA GORDA FL 33950

AUSTIN A AARDEMA MD 162
1470 PECK ST
MUSKEGUN MICHIGAN 49441

ALI A ABBASI MD 222
1211 ELMWOOD W
CLAWSON MI 48017

A ABBASSIAN MD 222
30900 FORD RD
GARDEN CITY MI 48135

JAMES A ABBOTT MD 222
810 MUTUAL BLDG
DETROIT MI 48226

R RODERIC ABBOTT MD 062
420 S BALLENGER HWY
FLINT MI 48504

VERNON C ABBOTT MD 174
1405 PONTIAC ST BK L
PONTIAC MI 48058

MARTIN M ABBRECHT MD 174
800 S ADAMS RD
8IRMINGHAM MI 48011

GERALD J ABEN MD 222
15901 W 9 MILE RD
SOUTHFIELD MI 48075

ARSENIU 8 ABLAU MD 106
1330 8RADFORD ST NE
GRAND RAPIDS MI 49503

ELIE D ABDULAFIA MD 222
18241 GREENFIELD
DETROIT MI 48235

A O ABRAHAM MD 114
327 W MAIN ST
HUDSON MI 49247

JOS P ABRAHAM MD 222
2799 W GRAND BLVD
DETROIT MI 48202

SAMUEL M ABRAMSON MD 222
15041 E SEVEN MILE RD
DETROIT MI 48205

ANTHONY M ABRUZZO MD 110
1568 RULANE DR
LAPEER MICHIGAN 48446

ROMULO T ABUEVA MD 102
1521 GULL RD
KALAMAZOO MI 49001

GERALD L ACKERMAN MD 190
4700 PINE HAVEN DR R
SAGINAW MICH 48603

H R ACKERMAN JR MD 174
909 WOODWARD AVE #104
PONTIAC MI 48053

JOHN R ACKERMANN MD 090
DEPT OF SURGERY MSU
EAST LANSING MI 48823

JAMES R ACOCKS MD 134
MORGAN HEIGHTS
MARQUETTE MICH 49855

JULIO B ACOSTA MD 222
27634 FIVE MILE RD
LIVONIA MI 48154

ROBIN ADAIR MD 174
800 S ADAMS
8IRMINGHAM MICH 48011

GERALD D ADAMIAN MD 222
15901 W 9 MILE RD
SOUTHFIELD MI 48075

ALBERT C ADAMS MD 062
5210 LAPEER RD
FLINT MI 48503

BURNELL H ADAMS MD 062
609 S LYNCH ST
FLINT MI 48503

CHARLES ADAMS MD 090
2909 E GRAND RIVER
LANSING MICHIGAN 48912

ELLIS W ADAMS MD 098
720 W FRANKLIN
JACKSON MICHIGAN 49201

FREDERICK M ADAMS MD 174
800 S ADAMS
8IRMINGHAM MI 48011

JAMES R ADAMS MD 222
39 SHADY HOLLOW DR A
DEARBORN MI 48128

URIAH M ADAMS MD 038

MARCELLUS MI 49067

VINCENT 8 ADAMS MD 222
19641 MACK AVE
GROSSE PTE MI 48236

ARTHUR ADAMSKI MD 222
19600 VAN DYKE
DETROIT MI 48234

ADELTO ADAN MD 154
3103 WASHINGTON
MIDLAND MI 48640

EARL R ADDISON MD 054
412 SUPERIOR AVE
CRYSTAL FALLS MICH 49920

IRWIN P ADELSON MD 222
1151 TAYLOR
DETROIT MI 48202

SEYMOUR S ADELSON MD 174
20905 GREENFIELD RD
SOUTHFIELD MI 48075

SIDNEY L ADELSON MD 222
16221 SCHOOLCRAFT
DETROIT MI 48227

SIDNEY ADLER MD 222
3011 W GRAND 8LVD L
DETROIT MI 48202

RAM ADVANI MD 106
1840 WEALTHY ST SE
GRAND RAPIDS MI 49506

MANOOCHEHR AGAH MD 222
6765 ORCHARD LAKE RD
ORCHARD LAKE MI 48033

VERINDER K AGGARWAL MD 222
3800 WOODWARD AVE #308
DETROIT MI 48201

NILS D AGNEBERG MD 146
531 1ST ST
MENOMINEE MICH 49858

GEO H AGNEW MD 222
3011 W GRAND 8LVD L
DETROIT MI 48202

BUSHARAT AHMAD MD 134
1414 W FAIR AVE
MARQUETTE MI 49855

ASIRUDDIN AHMAD MD 174
5770 M-15
CLARKSTON MI 48016

J H AHRONHEIM MD 098
569 WILDWOOD AVE
JACKSON MICH 49201

DONALD J AIKEN MD 090
GRANDVIEW & GRAND RV
OKEMOS MICH 48864

MANUEL A AIRALA MD 034
1554 E MICHIGAN
AL8ION MI 49224

MARTA S AIRALA MD 222
1554 E MICHIGAN
ALBION MI 49224

GEO T AITKEN MD 106
50 COLLEGE AVE SE
GRAND RAPIDS MI 49503

JAS J AIUTO MD 222
22811 MACK
ST CLAIR SHORES MI 48083

EDWARD P AJEMIAN MD 102
208 BRONSON MED CTR
KALAMAZOO MICH 49006

ISSA S AJLOUNI MD 222
2075 E 14 MILE RD
8IRMINGHAM MI 48008

ROGER M AJLUNI MD 222
17920 FARM RD
LIVONIA MI 48152

SYED S AKHTAR MD 190
1232 N MICHIGAN AVE
SAGINAW MI 48602

CECIL N AKROYD MD 222
16551 W WARREN
DETROIT MI 48228

EMIL J AL8AN JR MD 222
7940 ALLEN RD
ALLEN PARK MI 48101

A P ALBARRAN MD 222
WAYNE CO GEN HOSP
ELOISE MICH 48132

G DONALD ALBERS MD 106
203 PARIS AVE SE
GRAND RAPIDS MI 49503

MILLARD J AL8ERS MD 190
1227 N MICHIGAN AVE
SAGINAW MICH 48602

ROBT AL8ERS MD 186
601 MICHIGAN
HOLLAND MICHIGAN 49423

DONALD G AL8ERT MD 174
3535 W 13 MILE RD
ROYAL OAK MICHIGAN 48072

SAMUEL G ALBERT MD 066
103 SUFFULK ST
IRONWOUD MICH 49938

AL8ERT J ALBRECHT MD 222
15901 W NINE MILE RD
SOUTHFIELD MI 48075

ROBT W AL8RECHT MD 174
2111 CASS LAKE RD
KEEGO HAR8OR MI 48033

ARNOLD A ALBRIGHT MD 034
15550 M-66 N
BATTLE CREEK MI 49017

ELSA A ALCANTARA MD 222
9801 CONANT
DETROIT MI 48212

LUCILO C ALCANTARA MD 222
9801 CONANT
DETROIT MI 48212

KENT A ALCORN MD 022
1420 CENTER AVE R
BAY CITY MICH 48706

MARSHALL W ALCORN MD 022
1420 CENTER AVE
8AY CITY MICH 48706

ALFRED L ALDRICH MD 096

ITHACA MICH 48847

ALPHABETICAL DIRECTORY OF MSMS MEMBERS

NAPIER S ALDRICH MD 030
136 W CLAY
COLDWATER MICH 49036

CHAS W ALDRIDGE JR MD 106
1425 MICHIGAN ST NE
GRAND RAPIDS MI 49503

JUAN E ALEJOS MD 126
11885 E 12 MILE #102
WARREN MI 48093

ALLEN ALEXANDER MD 222
18881 HILTON
SOUTHFIELD MI 48075

ARDEN G ALEXANDER MD 162
975 W SEMINOLE
MUSKEGON MI 49441

C A ALEXANDER MD 102
118 W NORTH ST L
KALAMAZOO MICH 49007

DON K ALEXANDER MD 218
301 N INGALLS ST
ANN ARBOR MI 48104

EUGENE J ALEXANDER MD 222
34830 SPRINGVALLEY R
WESTLAND MI 48185

G D ALEXANDER MD 222
25799 LATHRUP BLVD
SOUTHFIELD MI 48075

JAMES H ALEXANDER MD 126
25815 HARPER
ST CLAIR SHORES MI 48081

L C ALEXANDER MD 222
1204 KALES BLDG
DETROIT MI 48226

LEROI J ALEXANDER MD 062
915 W PASADENA
FLINT MI 48504

REUBEN G ALEXANDER MD 090
133 CRUM ST L
LAINGSBURG MI 48848

WM H ALEXANDER MD 054
411 EAST C ST L
IRON MOUNTAIN MI 49801

FELIX S ALFENITO JR MD 106
515 LAKESIDE DR SE
GRAND RAPIDS MICH 49506

MANUEL A ALFONSO MD 222
21501 KELLY RD
EAST DETROIT MI 48021

BARRY H ALFORD MD 218
385 N MILL
PLYMOUTH MICHIGAN 48170

ELVIS S ALFORD MD 222
20 LIBERTY ST
BELLEVILLE MI 48111

GEORGE D ALGER M D 106
2410 GAYNOR AVE NW
GRAND RAPIDS MI 49504

S AKRAM ALI MD 194
1026 SUPERIOR ST
PORT HURON MI 48060

SHAFQAT ALI MD 222
115 E DUNLAP
NORTHVILLE MI 48167

PETER ALIFERIS MD 014
ALPENA GENERAL HOSP
ALPENA MI 49707

MINDA ALIMARIO MD 222
1005 HOLLYWOOD
GROSSE PTE WOODS MI 48236

JOHN L ALIPIT MD 078
32 S BROAD ST
HILLSDALE MI 49242

YASAR M ALKAR MD 174
159 PIERCE ST NO 202
BIRMINGHAM MI 48011

H DALE ALKEMA MD 102
1631 GULL RD
KALAMAZOO MI 49001

ROBERT D ALLABEN MD 222
18255 W MCNICHOLS RD
DETROIT MI 48219

DONALD J ALLCORN MD 062
1386 W COLDWATER RD
FLINT MI 48505

ARTHUR D ALLEN MD 022
101 W JOHN ST L
BAY CITY MI 48706

DUANE M ALLEN MD 098
HANOVER MEDICAL CTR
HANOVER MICHIGAN 49241

HUBERT M ALLEN MD 222
HENRY FORD HOSPITAL
DETROIT MI 48202

JOHN V ALLEN MD 222
1336 SOUTHFIELD RD
LINCOLN PARK MI 48146

J SCOTT ALLEN MD 222
16820 GREENFIELD
DETROIT MI 48235

R H ALLEN M D 034
191 COLLEGE
BATTLE CREEK MICH 49017

RICHARD J ALLEN MD 218
UNIVERSITY HOSPITAL
ANN ARBOR MICHIGAN 48104

RICHARD T ALLEN MD 162
768 W BROADWAY
MUSKEGON HTS MI 49444

ROBERT F ALLEN MD 170
LOCKWOOD HOSPITAL
PETOSKEY MI 49770

RUSSELL A ALLEN MD 114
689 STOCKFORD DR
ADRIAN MICHIGAN 49221

LYLE M ALLIS MD 218
2355 E STADIUM BLVD
ANN ARBOR MI 48104

HARRY D ALLIS MD 090
2909 E GRAND RIVER
LANSING MI 48912

HUGH R ALLOTT MD 042
816 ASHMUN ST
SAULT STE MARIE MICH 49783

BERNHARD T ALM MD 170
P O BOX 251 R
PETOSKEY MICH 49770

ISIDRO C ALMEDA MD 126
50511 VAN DYKE
UTICA MI 48087

MUFID B AL-NAJJAR MD 174
625 PURDY
BIRMINGHAM MI 48009

E BRYCE ALPERN MD 222
2840 W 7 MILE RD
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EDWARD ALPERT MD 126
11885 E 12 MILE RD
WARREN MI 48093

SAM ALPINER MD 222
2850 E SEVEN MILE RD
DETROIT MI 48234

MUHYI H AL-SARRAF MD 222
4160 JOHN R ST
DETROIT MI 48201

ADNAN ALSHABKHOUN MD 174
33100 12 MILE RD
FARMINGTON MI 48024

WILLIAM J ALT MD 162
MEDICAL ARTS CENTER
MUSKEGON MICHIGAN 49440

J K ALTLAND MD 090
ROUTE 2 BOX 178
LANSING MI 48917

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14633 E SEVEN MILE RD
DETROIT MI 48205

RAPHAEL ALTMAN MD 222
17000 WEST 8 MILE RD
SOUTHFIELD MI 48075

HERNAN ALVAREZ JR MD 222
HENRY FORD HOSP
DETROIT MI 48202

JULIAN ALVAREZ MD 222
260 LAKELAND
GROSSE PTE MI 48236

MERCEDES ALVAREZ MD 126
28532 SCHOENHERR RD
WARREN MI 48093

VICTOR M ALVAREZ MD 222
3745 MONROE
DEARBORN MI 48124

ROBT H AMBROSE MD 126
18801 E TEN MILE RD
ROSEVILLE MICH 48066

FLORENCE D AMES MD 158
2 W NOBLE AVE L
MONROE MI 48161

PARVIZ K AMID MD 174
3321 ROCHESTER RD
ROYAL OAK MI 48073

JAMES A AMLICKE MD 102
1219 SO PARK ST
KALAMAZOO MI 49001

ARTHUR L AMOLSCH MD 134
1008 BLUFF ST L
MARQUETTE MICHIGAN 49855

DAVID A AMOS MD 162
307 MEDICAL ARTS BLDG
MUSKEGON MI 49440

NORMAN H AMOS MD 034
ROUTE 1 BOX 450 R
AUGUSTA MI 49012

NORMAN O AMOS MD 034
710 NORTH AVENUE
BATTLE CREEK MI 49017

ROMULO S ANCUG MD 222
1151 TAYLOR
DETROIT MI 48202

LOURDES V ANDAYA MD 222
HARPER HOSPITAL
DETROIT MI 48201

BEVERLY L ANDERSON MD 222
977 SEXTON RD
HOWELL MI 48843

CHAS P ANDERSON MD 222
MEDICAL DIRECTOR
DETROIT MI 48201

DEPT OF SOCIAL SERV
640 TEMPLE AVE
DAVID G ANDERSON MD 218
2490 ADARE
ANN ARBOR MICH 48104

D HESS ANDERSON MD 094
207 BRIDGE ST
PORTLAND MICH 48875

DONALD T ANDERSON MD 054
408 HAMILTON AVE
KINGSFORD MICH 49801

EUGENE C ANDERSON MD 222
14801 SOUTHFIELD
ALLEN PARK MI 48101

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218 S 10TH ST
ESCANABA MICH 49829

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9500 E ORCHARD DR A
ENGLEWOOD CO 80110

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2337 W MT MORRIS RD
MT MORRIS MICH 48458

HAROLD E ANDERSON MD 034
131 E COLUMBIA AVE
BATTLE CREEK MI 49015

JERRY W ANDERSON MD 106
245 STATE ST SE
GRAND RAPIDS MICH 49502

JOHN L ANDERSON MD 062
2765 FLUSHING RD
FLINT MI 48504

MARY J ANDERSON MD 198
889 OLNEY RD
LEONIDAS MI 49066

NORMA ANDERSON MD 210
R#1 GERMANIA RD
SNOVER MI 48472

ROBERT L ANDERSON MD 054
DICKINSON CO MEM HOSP
IRON MOUNTAIN MI 49801

ROBT E ANDERSON MD 218
2136 S SEVENTH
ANN ARBOR MI 48103

R E ANDERSON MD 226
520 COBB ST
CADILLAC MI 49601

WALTER L ANDERSON MD 222
1553 WOODWARD AVE
DETROIT MI 48226

WM B ANDERSON MD 222
966 FISHER BLDG
DETROIT MI 48202

WM K ANDERSON MD 190
BOX 827 BLIND RIVER L
ONTARIO CANADA

F ANDRAKOVICH MD 174
5554 LAHSER RD
BIRMINGHAM MI 48010

HARVEY M ANDRE MD 106
21 MICHIGAN ST NE
GRAND RAPIDS MI 49502

LARRY J ANDREINI MD 050
DOCTORS PARK
ESCANABA MI 49829

BYRON ANDREOU MD 222
460 EASTLAND CTR
HARPER WOODS MI 48237

SHERMAN E ANDREWS MD 102
935 JOHN ST L
KALAMAZOO MI 49001

THOMAS E ANDREWS MD 102
1634 GULL RD #207
KALAMAZOO MI 49001

EUGENIUS ANG MD 218
CHELSEA MEDICAL CLINIC
CHELSEA MI 48118

HOWARD H ANGELL MD 102
UPJOHN COMPANY A
KALAMAZOO MI 49001

WALTER M ANGLIN MD 102
7211 LANTOLLARY RD A
KALAMAZOO MI 49004

RAHSAN ANISOGLU MD 222
18126 SHADBROOK
NORTHVILLE MI 48167

JOON-NAHM ANN MD 222
10151 MICHIGAN AVE
DEARBORN MI 48126

ODMENICO M ANNESSA MD 222
3536 BURNS AVE L
DETROIT MI 48214

G W ANNESSA MD 162
1470 PECK ST
MUSKEGON MI 49441

SHAPOOR ANSARI MD 158
750 STEWARD RD
MONROE MI 48161

MARY K ANSLEY MD 222
1101 DAV WHITNEY BLDG
DETROIT MI 48226

RICHARD D ANSLOW MD 222
1515 DAV WHITNEY BLDG
DETROIT MI 48226

RICHARD A ANTELL MD 062
3402 SANTA CLARA CT
FLINT MICHIGAN 48504

GEO E R ANTHONY MD 062
RR1 PORT LAMBTON R
ONTARIO CANADA

ROBERT C ANTLE MD 022
101 W JOHN ST
BAY CITY MICHIGAN 48706

PETER B APP MD 106
715 KENT HILLS RD NE
GRAND RAPIDS MI 49505

ROBT G APP MD 190
3422 DAVENPORT
SAGINAW MICHIGAN 48602

BEN A APPEL MD 102
252 E LOVELL ST
KALAMAZOO MICH 49006

SAUL APPEL MD 098
112 W MICHIGAN AVE
JACKSON MICH 49201

WILLIAM APPEL MD 102
252 E LOVELL ST
KALAMAZOO MI 49006

LLOYD E APPELL MD 102
126 N KALAMAZOO AVE
VICKSBURG MICH 49097

HOWARD B APPELMAN MD 222
1553 WOODWARD AVE
DETROIT MI 48226

JOSEPH N AQUILINA MD 190
3406 DAVENPORT
SAGINAW MI 48602

ROSITA N AQUINO MD 218
ST JOSEPH MERCY HOSP A
ANN ARBOR MI 48104

JAIME V ARAGONES MD 174
134 W UNIVERSITY DR
ROCHESTER MI 48063

AGUSTIN ARBULU MD 222
1400 CHRYSLER FREEWAY
DETROIT MI 48207

FEDERICO A ARCARI MD 174
606 N WOODWARD AVE
BIRMINGHAM MI 48011

RENE F ARCHAMBAULT MD 222
35550 MICHIGAN AVE
WAYNE MI 48184

DONALD H ARCHIBALD MD 182
BOX 223
ONTONAGON MICH 49953

EDUARDO ARCINIEGAS MD 222
26300 MEADOWBROOK WAY
LATHRUP VILLAGE MI 48076

LUCENIA ARCINUE MD 222
3901 BEAUBIEN
DETROIT MI 48201

BURKE W AREHART MD 222
340 EASTLAND BLDG
DETROIT MI 48236

MIGUEL A ARELLANO MD 126
21500 MOUND RD
WARREN MICHIGAN 48091

JOSEPH A ARENA JR M D 174
503 PIERCE
BIRMINGHAM MICHIGAN 48009

NORMAN J ARENDS MD 222
302 EASTLAND PROF BLDG
DETROIT MI 48236

WM ARENDSHORST MD 186
144 WEST 26TH ST
HOLLAND MI 49423

JOHN G ARENT MD 222
12600 1/2 GR RIVER AVE
DETROIT MI 48204

TURAN ARGUN MD 098
406 MCNEAL
JACKSON MI 49203

MOHAMMAD A ARIANI MD 222
EASTLAND PROF BLDG 314
HARPER WOODS MI 48225

C T ARIES MD 222
27216 CECILE AVE
DEARBORN HEIGHTS MI 48127

ULVE E ARIES MD 222
HERMAN KIEFER HOSP
DETROIT MI 48202

SEVERO R ARMADA JR MD 222
32900 FIVE MILE RD
LIVONIA MI 48154

ROBERT M ARMBRUSTER MD 062
626 MOTT FDTN BLDG
FLINT MI 48502

V W ARMBRUSTMACHER MAJ 106
MC-USAF A
OLNEY MARYLAND 20832

19309 MADISON HOUSE ST

THOS C ARMINSKI MD 222
23077 GREENFIELD RD
SOUTHFIELD MI 48075

HERMINIO ARMOVIT MD 114
236 S FOURTH ST
ONSTED MICHIGAN 49265

MAC J ARMSTRONG MD 222
600 LAFAYETTE E
DETROIT MI 48226

ROBT J ARMSTRONG MD 102
3336 LAKESHORE DR R
SAULT STE MARIE MI 49783

GEORGE C ARNAS MD 190
1600 N MICHIGAN AVE
SAGINAW MI 48602

A ROBERT ARNSTEIN MD 222
285 HAWTHORNE
BIRMINGHAM MI 48009

MORRIS ARNKOFF MD 222
15901 W NINE MILE RD
SOUTHFIELD MI 48075

ALFRED L ARNOLD JR MD 206
R 1 L
OVID MI 48866

WM J ARNOLD JR MD 222
12062 BROAD ST
DETROIT MI 48204

FORREST J ARNOLDI MD 222
HARPER HOSPITAL
DETROIT MI 48201

ROY E ARONS MD 174
7133 LINDENMERE
BIRMINGHAM MI 48010

R J ARRINGTON JR MD 222
3737 BEAUBIEN ST A
DETROIT MI 48201

ROBYN J ARRINGTON MD 222
7811 OAKLAND AVE
DETROIT MI 48211

ALFREDO B ARRIOLA MD 222
14827 E JEFFERSON
DETROIT MI 48215

RICHARD B ASBURY M D 022
2110 16TH ST
BAY CITY MICHIGAN 48706

MEYER S ASCHER MD 222
1508 DAV BRODERICK TWR
DETROIT MI 48226

RAYMOND ASHARE MD 174
35 S JOHNSON
PONTIAC MICHIGAN 48053

ROBERT N ASHBY MD 106
201 LAFAYETTE AVE SE
GRAND RAPIDS MI 49503

STILSON R ASHE MD 222
23030 CHERRY HILL L
DEARBORN MI 48124

LOWELL B ASHLEY MD 222
5811 N E 21 RD R
FT LAUDERDALE FL 33308

RALPH F ASKAM MD 162
MEDICAL ARTS CENTER
MUSKEGON MICHIGAN 49440

JAMES C ASKINS MD 098
214 N WEST AVE
JACKSON MI 49201

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207 N WALNUT ST R
BAY CITY MI 48706

CHARLES M ASPLUND MD 142
213 ELM ST
BIG RAPDIS MI 49307

DAVID C ASSELIN MD 090
1322 E MICHIGAN
LANSING MICHIGAN 48912

DEAN R ASSELIN MD 026
2817 S STATE ST
ST JOSEPH MI 49085

REGIS F ASSELIN MD 222
11417 WHITTIER
DETROIT MI 48224

MOHAMMED A ASSI MD 222
18161 W 12 MILE RD
LATHRUP VILLAGE MI 48075

RUSSELL M ATCHISON MD 218
501 W DUNLAP
NORTHVILLE MICH 48167

SABAH H ATCHU MD 174
21240 VIRGINIA
SOUTHFIELD MI 48075

ANNIE L ATKINSON MD 162
P O BOX 233 A
MONTAGUE MICHIGAN 49437

JAMES E ATKINSON MD 018
1005 W GREEN ST
HASTINGS MI 49058

ROBERT L ATKINSON MD 026
777-D RIVERVIEW DR
BENTON HARBOR MI 49022

MAX E AUBLE MD 222
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2791 WALTON BLVD
ROCHESTER MI 4B063

WM B MC INTYRE MD 222
20901 MOROSS RD
DETROIT MI 4B236

ORVAL I MC KAY MD 106
1150 N HUDSON ST
LOWELL MICH 49331

GEO E MC KEEVER MD 222
5237 OAKMAN BLVD
DEARBORN MI 4B126

CHAS J MC KENNA MD 222
1295 SUNNINGDALE R
GROSSE POINTE MI 4B236

JAMES MCKENNA MD 222
573 FISHER BLDG
DETRUIT MI 4B202

MARVIN J MCKENNEY MD D90
120D MICHIGAN AVE
EAST LANSING MI 4BB23

LELAND M MC KINLAY MD 106
403 DIXIE DR SOUTH R
HOWEY IN HILLS FL 32737

ROY J MCKINNEY MD 174
3535 W 13 MILE RD #306
ROYAL OAK MI 4B072

EDWIN R MC KNIGHT MD 206
320 N WASHINGTON ST
OWOSSO MICH 4BB67

ROBT D MC KNIGHT MD 17D
LINCOLN PLACE
PETOSKEY MICH 49770

ROBT E MCKNIGHT MD 222
15901 W 9 MILE RD
SOUTHFIELD MI 4B075

MYRTLE S MCLAIN MD 106
645 DAKLEIGH N W
GRAND RAPIDS MI 49504

HARRIET I E MC LANE MD 222
1367 NICDLET PLACE L
DETRDIT MI 4B207

J H MC LAUGHLIN MD 174
604 NORTH WOODWARO
BIRMINGHAM MICHIGAN 4B011

JOHN M MC LAUGHLIN MD D9B
71D S BROWN ST
JACKSON MICH 49203

MIAR J MC LAUGHLIN MD 09B
710 S BROWN ST L
JACKSON MI 49203

JAMES T MCLAUGHLIN MD 222
WYANDOTTE GEN HOSP
WYANDOTTE MI 4B192

JASPER E MCLAURIN MD 222
6001 W OUTER DR #137
DETROIT MI 4B235

H B MC LAUTHLIN MD 09B
1123 S BROWN ST
JACKSON MICH 49203

BRITA R MC LEAN MD 222
1365 CASS
DETRUIT MI 4B226

DON W MC LEAN MD 222
23077 GREENFIELD RD L
SOUTHFIELD MI 4B075

DONALD C MC LEAN M D 222
459 FISHER BLDG
DETROIT MI 4B202

I WM MCLEAN JR MD 222
PARKE DAVIS & CO
DETROIT MI 4B232

JOSEPH CAMPAU @ RIVER

JAMES A MCLEAN MD 21B
1313 E ANN ST
ANN ARBOR MICH 48104

DOUGLAS MCLEARON MD 11B
2149 W GRAND RIVER
HOWELL MI 4BB43

J T MC LELLAND MD 026
MERCY HOSP X RAY DEPT
BENTON HARBOR MICH 49022

THOMAS A MC LENNAN MD 062
913 MOTT FNDTN BLDG
FLINT MI 4B502

KENNETH W A MC LEOD MD 062
607B WINGED FOOT DR
GRAND BLANC MI 48439

THOMAS V MCMANAMON MD 222
23470 MEADOW PARK
DETROIT MI 4B239

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TRAVERSE CITY MI 49684

KATHRYN MC MORROW MD 126
22900 E REMICK
MT CLEMENS MI 4B043

RICHARD J MC MURRAY MD 062
2765 FLUSHING RD
FLINT MICH 48504

JOHN N MC NAIR MD 162
936 SECOND ST
MUSKEGON MICH 49440

WM E MCNALLY MD 102
325 E CENTRE ST
PORTAGE MI 490B1

B EDWARD MC NAMARA MD 090
BDX 24B N
FAIRPLAY CD 80440

JDSEPH M MC NAMARA MD 222
9430 S MAIN
PLYMOUTH MI 48170

D W MCNAUGHTDN MD 062
2437 PINEWDDD CT
FLUSHING MI 4B433

HOWARD H MC NEILL MD 174
225 W HICKORY GROVE RO L
BLOOMFIELO HILLS MI 4B013

ROGER F MC NEILL MD 222
63 KERCHEVAL
GROSSE PTE MI 48236

L J MCNICHOL MD 222
15901 GREENFIELD
DETROIT MI 4B227

EOWARD C MC PHEE MD 174
909 WOODWARD
PONTIAC MICH 4B053

RODERICK T MC PHEE MD 222
1462B E 7 MILE RD
DETROIT MI 4B2D5

MARK C MCQUIGGAN MD 174
29653 CLUB HOUSE LANE
FARMINGTON MI 4B024

MARK R MC QUIGGAN MD 222
1050 FISHER BLDG L
DETROIT MI 4B202

THELMA H MCQUIGGAN MO 222
24908 CHERRYHILL
OEARBORN MI 4B124

F P MC QUILLAN MD 09B
405 S HIGBY A
JACKSON MICHIGAN 49203

LEO B MC SHERRY JR MD 022
130B COLUMBUS AVE
BAY CITY MICH 4B706

DAVID MC TAGGART M D 062
625 S GRAND TRAVERSE
FLINT MICHIGAN 4B503

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1D23 E MICHIGAN
LANSING MICHIGAN 4B912

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26B5 OVERRIDGE DR
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915 S HIGBY L
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JOSEPH F MEARA MD 222
OETROIT MEM HOSP
DETROIT MI 4B226

PAUL E MEDEMA MD 162
1661 CLINTON ST L
MUSKEGON MICH 49442

G MEDINA MD 126
B425 E 12 MILE RD
WARREN MI 48093

GIL H MEDIODIA MD 222
22912 CANTERBURY
ST CLAIR SHORES MI 4B0B0

ROBT E MEDLAR MD 098
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JACKSON MICH 49203

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YPSILANTI MI 48197

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134 COLE RD
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RICHARD B MICHELSON MD 062
2014 ROBT T LONGWAY
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W S MIDDLETON MD 158
219 W FRONT STREET
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DETROIT MI 48205

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15361 PLYMOUTH RD
DETROIT MI 48227

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261 GOLFVIEW DR
CARO MI 48723

WM K MILES MD 218
A

HUGH H MILEY MD 222
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23100 CHERRY HILL
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18001 HAMILTON RD
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8454 CANDLEWOOD R
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21519 HARPER
ST CLAIR SHORES MI 48080

GLENN F MILLER MD 190
2224 MERSHON
SAGINAW MICHIGAN 48602

HAZEN L MILLER MD 174
STAR ROUTE BOX 247A L
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16210 W 9 MILE RD #109
SOUTHFIELD MICHIGAN 48075

IRA I MILLER MD 218
1718 HERMITAGE RD
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IRVING M MILLER MD 174
23023 ORCHARD LAKE RD
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20131 JAMES COUZENS
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2799 W GRAND BLVD
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50 COLLEGE AVE SE
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DETROIT MI 48226

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27330 SOUTHFIELD RD L
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820 N E 33RD ST L
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FLEETWOOD PLT FBD GMC
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P LYNFORD MILLER MD 114
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BIRMINGHAM MI 48008

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WARREN MICHIGAN 48093

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361 MERTON RD L
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5649 INKSTER RD
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224 CIRCLE DR
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CLINTON C MILLS MD 222
13938 SARASOTA L
DETROIT MI 48239

GEO R MILLS MD 222
8209 ALLEN ROAD
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915 S GRAND TRAVERSE
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234 VISGER
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R

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SOUTHFIELD MI 48075

MORTEZA MINUI MD 222
1576 KIRKWAY DR
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DETROIT MI 48209

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25700 W OUTER DR
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HOLT MI 48842

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4651 E NINE MILE RD L
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DETROIT MI 48216

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140 ELIZABETH LK RD
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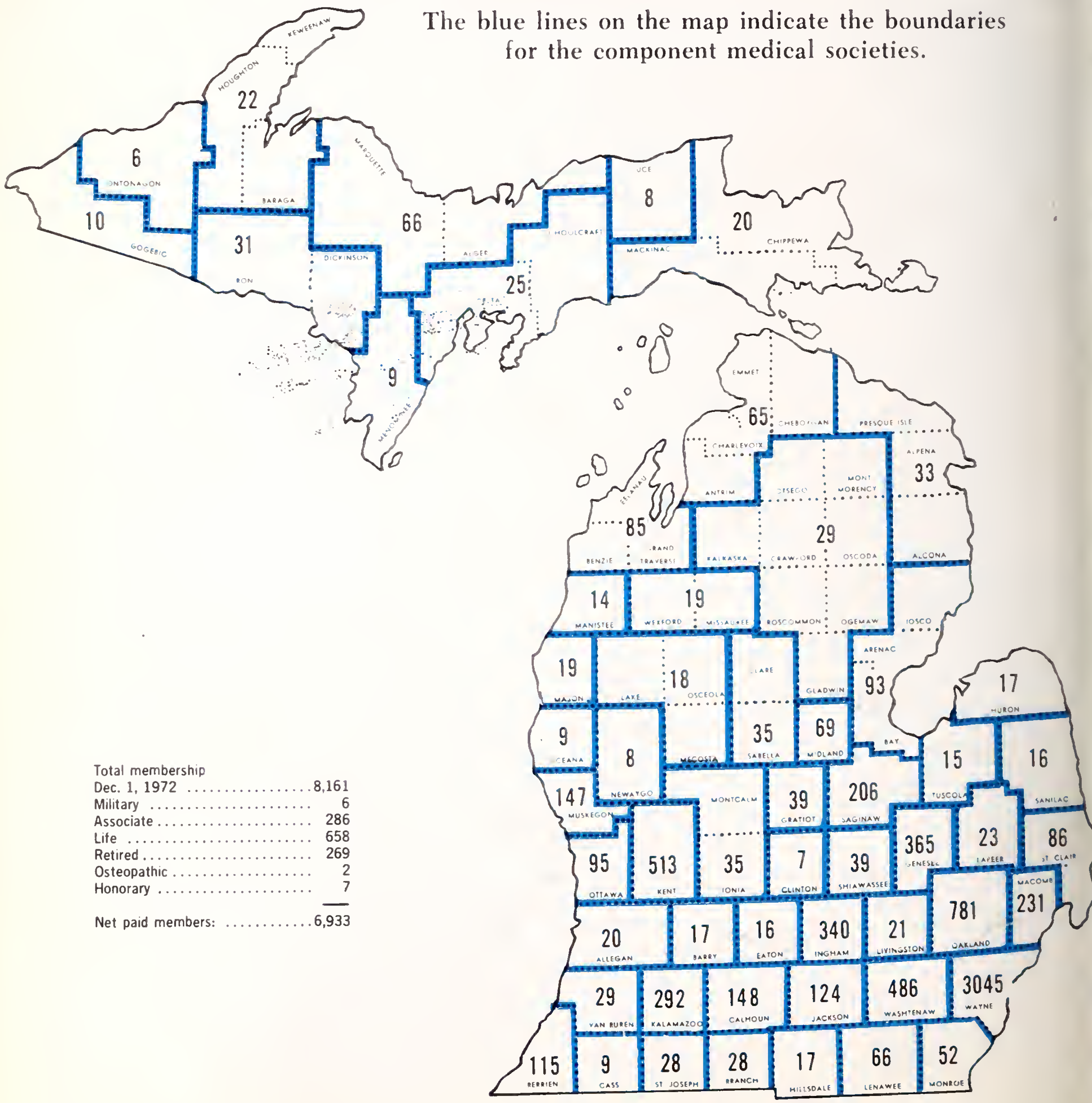
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5-mg, 10-mg, 25-mg capsules
up to 100 mg daily in severe anxiety

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.
Contraindications: Patients with known hypersensitivity to the drug.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported Also encountered are isolated instances o skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltag fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
Supplied: Librium® capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

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Division of Hoffmann-La Roche Inc.
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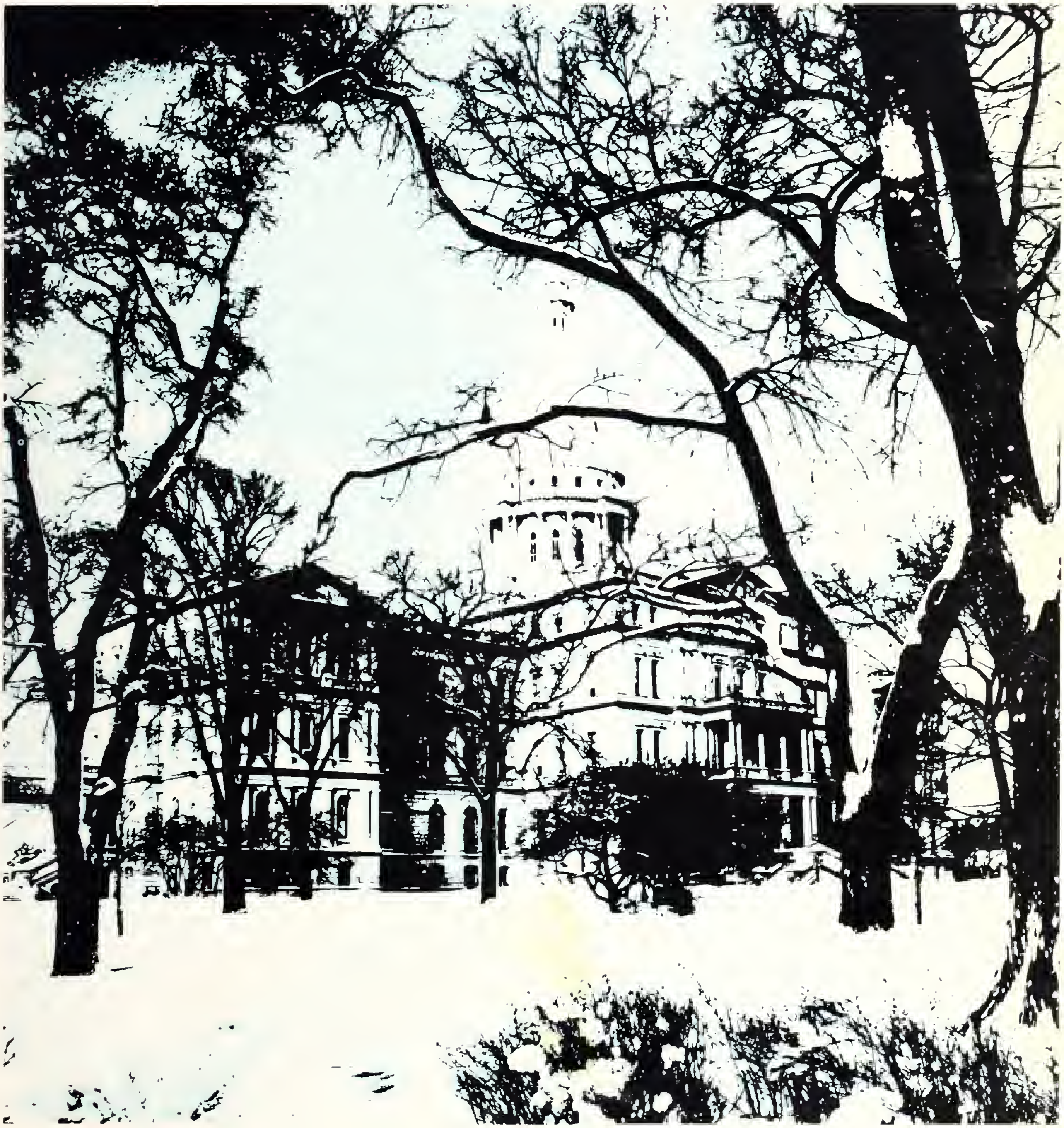
DECEMBER 1973



1973 Fall MSMS House of Delegates Digest of Proceedings . . . see Page 877

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MODEL YEAR

1974

Revised 10/15/73

1974

NEW AUTO & TRUCK LEASING

McCullagh Leasing, Inc. is offering an exclusive lease plan to members of THE MICHIGAN STATE MEDICAL SOCIETY at the same low rate as a large fleet user.

ADVANTAGES

Your financial advisor can tell you of the tax advantages you will gain under this plan. Some of the other plus features are the avoidance of confusion and time consuming chores of price comparison shopping. The cash equity that you now have in your present vehicle can be reinvested or put to other personal use.

THE PLAN

All leases are for twenty-four (24) months. All are Net, or Closed End, which means there is no residual liability upon completion of the lease. You are not required to guarantee that the car will bring any certain amount. Also, you would not be required to make up any difference in the selling price. Thus, the lessee pays a fixed cost, the total which is known to the penny in advance.

Michigan license plates are included in the rate for the full term of the lease.

All leases are for a maximum of fifty thousand (50,000) miles. Any mileage accrued in excess of 50,000 miles will be charged at the rate of two cents (.02) per mile.

Delivery is included anywhere in Michigan and will be performed by a McCullagh Leasing contract driver, at your convenience, directly to your front door. The car will be properly licensed, serviced, and washed. There is no need for you to consume valuable time on this matter.

INSURANCE

You provide your own insurance. The required limits are $100,000.00-$300,000.00 Liability, $50,000.00 Property Damage, $100.00 Deductible Collision plus comprehensive, fire and theft.

MAINTENANCE

Maintenance is not included, but as part of this leasing program you will be furnished a McCullagh Purchase Card for tires, parts and accessories for the leased car with savings from 25% to 43% whenever they are available. Contact representative for McCullagh Leasing Maintenance Program if desired.

The prices quoted will be for members only, but cars may be driven by personnel authorized by lessee when insurance is provided by the memher.

All rates are subject to a Michigan Use Tax on the monthly rental.

A security deposit is required on each unit in the amount of $200.00. This is returned to you upon full premium of the lease.

Listed here are models and equipment. Should we not list your choice of vehicle, please call McCullagh representative.

The New Car Leasing Program of McCullagh Leasing, Inc. has been investigated by The Council Finance Committee and approved by The Council for consideration by the membership, but MSMS makes no warranties or guarantees concerning the operator of the Car Leasing Program.

GROUP I

	Per Month
Cadillac DeVille *	
Coupe	$200.00
Sedan	214.00
Cadillac Eldorado **	
Coupe	235.00
Convertible	245.00
Chrysler Imperial LeBaron **	
2-Door Hardtop	200.00
4-Door Hardtop	214.00
Lincoln Continental **	
2-Door Coupe	208.00
4-Door Sedan	215.00
Lincoln Mark IV **	251.00

PRICE INCLUDES: Standard Equipment, Air Conditioning, Tinted Glass, Vinyl Roof, Whitewall Tires, AM-FM Radio, Power Seat-six way.

* AM-FM Stereo Radio

** The above, plus door edge guards, cruise control, tilt wheel, power door locks, rear window defogger.

GROUP II

	Per Month
Chrysler New Yorker Brougham	
4-Door Hardtop	$160.00
Buick Electra Custom	
4-Door Hardtop	162.00
Buick Riviera	165.00
Ford Thunderbird	170.00
Mercury Marquis Brougham	
4-Door Hardtop	162.00
Oldsmobile Ninety-Eight Luxury	
Sedan	158.00
Oldsmobile Toronado Custom	170.00
Pontiac Bonneville	148.00
Pontiac Grandville	
4-Door Hardtop	157.00
Pontiac Grand Prix	156.00

PRICE INCLUDES: Standard Equipment, Standard V-8 Engine, Automatic Transmission, Power Steering, Power Disc Brakes, AM-FM Radio, Air Conditioning, Tinted Glass, Power Windows, Whitewall Tires, Vinyl Roof, Body Side Mouldings.

GROUP III

	Per Month
Buick LeSabre Luxus & Custom	
4-Door Hardtop	$132.00
Centurion	140.00
Chrysler Newport Custom	
4-Door Hardtop	152.00
Newport Royal	152.00
Dodge Monaco	
4-Door Hardtop	137.00
Mercury Monterey Custom & Monterey	
4-Door Hardtop	130.00
Oldsmobile Delta 88 Royale	
4-Door Hardtop	141.00
Pontiac Catalina	
4-Door Hardtop	134.00

PRICE INCLUDES: Standard Equipment, Standard V-8 Engine, Automatic Transmission, Power Steering, Power Disc Brakes, AM Radio, Air Conditioning, Tinted Glass, Vinyl Roof, Whitewall Tires, Body Side Mouldings.

GROUP IV

	Per Month
Buick Century Luxus & Custom	
2 or 4-Door Hardtop	$120.00
Chevrolet Impala Custom	
2 or 4-Door Hardtop	115.00
Chevrolet Monte Carlo "S"	
2-Door Hardtop	119.00
Ford Galaxie 500	
2 or 4-Door Hardtop	115.00
Plymouth Fury III	
2 or 4-Door Hardtop	115.00
Oldsmobile Cutlass Supreme	
2 or 4-Door Hardtop	117.00
Mercury Montego	112.00
Mercury Montego MX Brougham	
2 or 4-Door Hardtop	115.00
Pontiac Luxury Lemans	
2 or 4-Door Hardtop	115.00

PRICE INCLUDES: Standard Equipment, Standard V-8 Engine, Automatic Transmission, Power Steering, Power Disc Brakes, AM Radio, Air Conditioning, Tinted Glass, Whitewall Tires, Body Side Mouldings.

GROUP V

	Per Month
Chevelle Malibu Classic Coupe	$109.00
Sport Coupe	109.00
Ford Gran Torino 2 or 4-Door Hardtop	116.00
Plymouth Sebring 2 or 4-Door Hardtop	109.00

PRICE INCLUDES: Standard Equipment, Standard V-8 Engine, Automatic Transmission, Power Steering, Power Disc Brakes, AM Radio, Air Conditioning, Tinted Glass, Whitewall Tires, Body Side Mouldings.

Optional Equipment

Group I thru V (per month) if not included in price:

	Per Month
AM-FM Radio	$ 3.00
Power Door Locks 2-Door	1.75
Power Door Locks 4-Door	2.75
Cruise Control	2.00
Power Windows	3.50
AM-FM Stereo Radio	7.75
Tilt Steering Wheel	2.00
Power Seat – Six Way	3.00
Vinyl Roof (Group IV and V)	2.50

GROUP VI

		Per Month
1)	Chevelle Concours Estate Wagon	$129.00
2)	Ford Gran Torino Squire Wagon	129.00
3)	Chevrolet Impala Wagon	123.00
4)	Chevrolet Caprice Wagon	128.00
5)	Ford Country Sedan Wagon	123.00
6)	Ford Country Squire Wagon	134.00
7)	Olds Vista Cruiser Wagon	130.00
8)	Buick Estate Wagon Wood Grain	152.00
9)	Mercury Marquis Colony Park	148.00
10)	Oldsmobile Custom Cruiser	159.00

PRICE INCLUDES: Standard Equipment, Standard V-8 Engine, Automatic Transmission, Power Steering, Power Disc Brakes, AM Radio, Air Conditioning, Tinted Glass, Whitewall Tires, Body Side Mouldings. All 9-10 Passenger.

GROUP VII

	Per Month
Chevrolet Vega Hatchback Coupe	$ 90.00
Ford Pinto Runabout - 3 Door	84.00
Mercury Comet 2-Door Sedan	90.00
Plymouth Valiant Duster Coupe	90.00

PRICE INCLUDES: Standard Equipment, Standard Engine, Automatic Transmission, Power Steering, AM Radio, Whitewall Tires, Body Side Mouldings.

Air Available on Group VII vehicles.

GROUP VIII

COMMERCIAL VEHICLES (TRUCKS)

All Commercial Vehicles are on a Finance (Open-End) Lease Plan. Under this Finance (Open-End) Lease, the lessee retains all the control; operations, maintenance, selection of accessories, makes and models of vehicles remains in the customer's hands. This includes all usage expenses, such as taxes, repairs, licenses, gasoline, oil and insurance. There are no mileage restrictions.

Contact McCullagh Leasing Agent on your specific Commercial Vehicle requirements and a detailed explanation of the Finance (Open-End) Lease Plan.

NOTE: *Rates quoted are subject to fluctuation due to the revision of Manufacturers' published retail prices and changes in the prime interest rate.*

For any further information, contact your McCullagh representative.

McCullagh Leasin
Automobile
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MSMS

30803 Little Mack
Roseville, Michigan 48066
Phone (313) 294-7800

Complete this form and send to
McCullagh Leasing

BUSINESS APPLICATION ☐ **INDIVIDUAL APPLICATION** ☐

Name ____________________

Address ____________________

City ____________________ State ____________

Zip ____________ Phone: Office ____________

Home ____________

Years in Business
(if company) ____________________

*Social Security No. ____________________

*Age ____________ No. Dependents ____________

BANK REFERENCES

Checking ____________ Acct. # ____________

Location ____________________

Savings ____________ Acct. # ____________

Location ____________________

OTHER CREDITORS

Name ____________________

Location ____________________

Name ____________________

Location ____________________

Name ____________________

Location ____________________

*Fill in only if lease is in individual name.

10-15-73

Some general advantages of....

Leasing can help keep working capital intact. Retained working capital can bring higher yields from sales, product and market development. Your cash can work where it is needed most.

enables you to convert presently owned fixed assets into working capital.

acts as a hedge against inflation because tomorrow's costs are paid with tomorrow's dollars.

saves existing credit lines for seasonal or emergency needs, thus preserving freedom to respond to the unexpected or to counter competition.

improves cash-flow by reducing initial cash outlay and by spreading the rentals over the useful life of the leased equipment.

none of the expenses normally associated with debt and equity financing such as commissions, legal, accounting and other such fees are charged to you. Leasing overcomes the disadvantages of the dilution of ownership brought about by additional financing through equities.

generally, lease payments are fully tax deductible. By moving capital investments into the fixed monthly expense column on the books, your company's tax load may be reduced. Leasing can also reduce administrative costs by eliminating the necessity to maintain depreciation and interest schedules. Simplified cost accounting, cost distribution procedures and more precise budget control, also usually result through leasing. One monthly invoice can cover all items leased.

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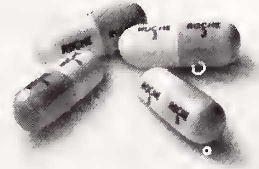
How strong must a tranquilizer be for severe anxiety?

As strong as Librium® 25 mg (chlordiazepoxide HCl)

The achievement of desired therapeutic results is often a function of the dosage *strength* as well as the drug's intrinsic action. Thus, when anxiety is *severe*, the 25-mg strength of Librium frequently provides the necessary antianxiety action with a minimum of unwanted adverse reactions. Librium 25 mg is a convenient dosage form for the relief of severe, incapacitating anxiety, specifically formulated to supplement your counsel and reassurance.

Benefits-to-risks ratio permits higher dosage



For over 13 years, Librium has been recognized for its excellent benefits-to-risks ratio, an asset in the *higher* dosage ranges as in more common clinical applications. Thus, the frequency of dosage with Librium 25 mg can be flexibly adjusted to the needs and response of the individual patient, up to 100 mg daily if required. Total daily dosage for the elderly and debilitated should not exceed 20 mg. When severe anxiety has been reduced, Librium dosage should be correspondingly reduced or discontinued entirely.

basic support in severe anxiety
Librium® 25 mg
(chlordiazepoxide HCl)
1 capsule t.i.d./q.i.d.

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, N J 07110

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

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